WHH Board of Directors Meeting Part 1 (Held in Public)

Wednesday 27 July 2022
10.00am-12.30pm
Trust Conference Room/Via MS Teams

TRUST BOARD MEETING – PART 1 *(Held in Public)*
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AGENDA ITEM	TIME	AGENDA ITEM	OBJECTIVE/DESIRED OUTCOME	PROCESS	PRESENTER
BM/22/07/81 **PAGE 6**	**10:00**	Engagement Story – Perinatal Mortality Review Tool– Parent's Perspective	***To Note***	**Presentation**	Dr Rita Arya, Consultant Obstetrician and Gynaecologist
BM/22/07/82	**10:15**	Welcome, Apologies and Declarations of Interest	***To note***		Steve McGuirk Chairman
BM/22/07/83 **PAGE 13**	**10:17**	Minutes and Action Log of the previous meeting held on 25 May 2022	***For decision***	***Minutes***	Steve McGuirk, Chairman
BM/22/07/84	**10:20**	Matters Arising	***For assurance***	***Verbal***	Steve McGuirk, Chairman
BM/22/07/85	**10:25**	Chief Executive's Report *(to follow)*	***For assurance***	***Report***	Simon Constable, Chief Executive
BM/22/07/86 **PAGE 26**	**10:30**	Chairman's Report • CMAST Briefing	***For info/update***	***Verbal & Paper***	Steve McGuirk, Chairman

Quality People Sustainability

BM/22/07/87	**10.40**	Covid-19 Situation Report *(to follow)*	***To Note for Assurance***	***Report***	Simon Constable, Chief Executive
BM/22/07/88 **PAGE 32** **PAGE 41**	**10:45**	Integrated Performance Reports (IPR) and Assurance Committee Reports i) IPR Development and NHSE Oversight Framework Update ii) IPR Dashboard	***For assurance***	***Report***	All Executive Directors
(a) **PAGE 104**		**Quality Dashboard** Monthly Nurse Safe Staffing Report	***For assurance***	***Report***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
(b) **PAGE 116**		Assurance Report – Quality and Assurance Committee (7.6.22 & 5.7.22)	***To note for assurance***	***Report***	Cliff Richards, Committee Chair/Jayne Downey, NED
(c) **PAGE 122**		**People Dashboard** Assurance Report Strategic People Committee (20.07.22)	***For assurance***		Michelle Cloney, Chief People Officer
(d) **PAGE 125**		**Sustainability Dashboard**	***For assurance***		Andrea McGee, Chief Finance Officer & Deputy CEO
(e) **PAGE 129**		Assurance Report – Finance and Sustainability Committee (22.06.22) Clinical Recovery Oversight Committee (21.06.22)	***For assurance***	***Report***	Julie Jarman, NED/Andrea McGee Chief Finance Officer & Deputy CEO Cliff Richards, NED

(f) PAGE 132		Assurance Report – Audit Committee (16.6.22)	***To note for assurance***	***Report***	Mike O'Connor, Committee Chair

Quality					
BM/22/07/89 **PAGE 134**	**11.40**	Move to Outstanding (M20) Update	***To note for assurance***	***Report***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/07/90 **PAGE 150** **PAGE 160** **PAGE 169** **PAGE 178**	**11.50**	Maternity Update including; • Cheshire & Mersey PMRT (Q2) • Maternity Incentive Schemes & Birth Rate Plus • Maternity Governance • Ockenden *(appendices included with Supplementary papers)*	***To note for assurance***	***Report***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO

People					
BM/22/07/91 **PAGE 187**	**12.05**	Engagement Dashboard Q1 Report	***To note for assurance***	***Report***	Pat McLaren, Director of Communications & Engagement

Sustainability					
BM/22/07/92 **PAGE 195**	**12.10**	Use of Resources Q1 Report	***To note for assurance***	***Report***	Andrea McGee, Chief Finance Officer & Deputy CEO
BM/22/07/93 **PAGE 224**	**12.15**	WHH as an anchor • Update on health inequalities, social value and the green agenda	***To note for assurance***	***Report***	Lucy Gardner Director of Strategy & Partnerships
BM/22/07/94 **PAGE 246**		Trust Strategy Refresh Plan	***To note for assurance***	***Report***	Lucy Gardner Director of Strategy & Partnerships

GOVERNANCE					
BM/22/07/95 **PAGE 253**		Board Assurance Framework	***To note for assurance***	***Report***	John Culshaw Trust Secretary

SUPPLEMENTARY PAPERS (See Supplementary Pack for Page Numbers)

FOR APPROVAL						
BM/22/07/96		Cycle of Business Strategic People Committee	***For approval***	Committee: Strategic People Committee Date of Meeting: 20/07/22 Agenda Ref: SPC/07/73 Outcome: Supported	***Paper***	John Culshaw Trust Secretary

TO NOTE FOR ASSURANCE						
BM/22/07/97		EPRR Annual Report	***For approval***	Committee: Finance & Sustainability Committee Date of Meeting: 20 July 2022 *Meeting cancelled – Chair's action taken to approve*	***Paper***	Dan Moore, Chief Operating Officer

BM/22/07/98		Charities Commission Checklist (Annual Review)	***For approval***	Committee: Charitable Funds Committee Date of Meeting: 27.06.22 Agenda Ref: CFC/22/06/10(b) Outcome: Approved	***Paper***	Pat McLaren, Director of Communications & Engagement
BM/22/07/99		Infection Prevention and Control Annual Report	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 7 July 2022 Agenda Ref: QAC/22/07/180	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/07/100		Infection Prevention and Control - Board Assurance Framework	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 7 July 2022 Agenda Ref: QAC/22/07/181 Outcome: Noted for assurance	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/07/101		Digital Board Report	***To note for assurance***	Committee: Finance & Sustainability Committee Date of Meeting: 20 July 2022 *Meeting cancelled – Chair's action to note for assurance*	***Paper***	Paul Fitzsimmons Executive Medical Director
BM/22/07/102		Clinical Recovery Oversight Committee – Chairs Annual Report	***To note for assurance***	Committee: Clinical Recovery Oversight Committee Date of Meeting: Agenda Ref: Outcome: Notes for assurance	***Paper***	Terry Atherton, Committee Chair
BM/22/07/103		Complaints Annual Report	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 7 June 2022 Agenda Ref: QAC/22/06/152 Outcome: Approved	***Paper***	Kimberley Salmon-Jamieson, Chief Nurse & Deputy CEO
BM/22/07/104		Medicines Management & Controlled Drugs Annual Report	***To note for assurance***	Committee: Quality Assurance Committee Date of Meeting: 7 June 2022 Agenda Ref: QAC/22/06/157 Outcome: Noted for assurance	***Paper***	Paul Fitzsimmons, Executive Medical Director
BM/22/07/105		Workforce Race Equality Standards (WRES)	***To note for assurance***	Committee: Strategic People Committee Date of Meeting: 20/07/22 Agenda Ref: SPC/07/77 Outcome: Supported	***Paper***	Michelle Cloney, Chief People Officer
BM/22/07/106		Workforce Disability Equality Standards (WDES)	***To note for assurance***	Committee: Strategic People Committee Date of Meeting: 20/07/22 Agenda Ref: SPC/07/78 Outcome: Supported	***Paper***	Michelle Cloney, Chief People Officer
CLOSING						
BM/22/07/107		Any other business		Steve McGuirk, Chair		
Date of next meeting – Wednesday 28 September 2022						

Conflicts of Interest

At any meeting where the subject matter leads a participant to believe that there could be a conflict of interest, this interest must be declared at the earliest convenient point in the meeting. This relates to their personal circumstances or anyone that they are of at the meeting.

- Chairs should begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the organisation's register(s) on completion of a Declaration of Interest Form.
- The Vice Chair (or other non-conflicted member) should Chair all or part of the meeting if the Chair has an interest that may prejudice their judgement.

If a member has an actual or potential interest the Chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and decision.
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.

Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

Interests fall into the following categories:

- **Financial interests:**
  Where an individual may get direct financial benefit[1] from the consequences of a decision they are involved in making.
- **Non-financial professional interests:**
  Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.
- **Non-financial personal interests:**
  Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
- **Indirect interests:**
  Where an individual has a close association[1] with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

PMRT: Parents' perspective

Pep Marie Shawcross

Our journey with Pep

- Referral to Liverpool Women's for confirmation of right-sided aorta following 20-week scan
- Diagnosis of severe cholestasis mid-third trimester
- Diagnosis of hypertension (but not pre-eclampsia) at 36+5
- Confirmation that Pep had passed away in utero at 36+6
- Pep was born at 37+1 (16th October 2020)
- Asked what level of investigation we would like the same night (but it was made clear that we could defer any decision)
- Post mortem was completed just under 1 week later
- Meeting with Dr Arya to discuss post mortem findings 3 months later (29th January 2021)
- Received copy of PMRT report via post after this

Our input to the PMRT at the time

"We first and foremost just want to say how happy we were with the care we received during our pregnancy, in particular the care within the bereavement suite, which was exceptional. Every single midwife we interacted with there - Ayesha (apologies for any misspelling), Gill, Jane, and especially Sarah and Laura. We're sure there were others but it's a bit of blur. They treated us with endless compassion, dignity and genuine care/feeling, and made an impossible time that bit easier, and the birth itself ended up being a beautiful and peaceful experience."

"The only point that we would like to raise is the decision that was made on Tues 13th to book the induction for Friday 16th. We're most definitely not looking to place blame or look at any "what ifs", but looking into the research regarding obstetric ICP, there are some guidelines (albeit not the RCOG) which suggest induction at 35-36 weeks when bile acid levels are ≥100 µmol/L. In my case, on that Tues, in addition to escalating bile acid levels, I had been reporting progressively reduced foetal movements for 3 days, and my BP was extremely elevated, which to us would perhaps add weight to the case for early induction, which we actually requested/suggested on that day (Tues 13th). Once again, there's no way to know if this would have changed the course of events, but we felt compelled to mention this, just in case it prompts a review of current hospital policy/guidelines for future cases."

Our thoughts on the PMRT process

- We appreciated the fact that we were **given options** regarding the level of investigation to be undertaken on Pep and that we were under **no time pressure** to decide
- Dr Arya presented us with some very difficult post mortem results in a **compassionate** yet **clear and up front manner**, adapting what was being explained to satisfy both our **levels of understanding** (Heather with a medical background, Lloyd without)
- We were grateful for the **transparency** of us being given a copy of the full report and the open way in which the report found that an **error of judgement** had been made in not admitting us to hospital following the high blood pressure findings
- We appreciated that the PMRT report included not only **acknowledgment of a mistake** than had been made, but also **what actions were being taken as a result**
- As a couple we are slightly divided on our opinion of the timescale involved – for Heather it felt like **quite a long time** before we received the findings; for Lloyd it gave him the **time he needed to digest** what had happened for himself before getting the results

Our care after Pep…

- **We were treated with such genuine care and dignity throughout**
  - For example, when we called to ask the ward a question the day after we went home, Jonathan let us know that he had taken Pep down to the mortuary, and made sure to let us know that her 4Louis bear was still with her and that she looked very peaceful
- We were linked with **Debbie** as bereavement midwife, who **checked in with us regularly in person** to see how we were, and was also a huge help in navigating the **practical arrangements** (e.g. registering the stillbirth) – this was absolutely invaluable
- Although **counselling** wasn't for us, we were regularly made aware that it was **available if we ever wanted it**

…and with Seth!

- Scans and midwife appointments every 2 weeks (alternating, so **seen weekly**)
  - These appointments were a **lifeline** for us during an extremely worrying and stressful time. Each appointment would settle our nerves, which would then **build again in intensity** until our next check
    - We feel it is important for the team to know just how **crucial every single check/interaction is**
  - We had the same midwife, Sarah, throughout – we valued the **continuity of care**, having a midwife who knew out history and concerns
  - The team made sure we were **never waiting long to be seen**, which we appreciated, given how long we had to wait (nearly 4 hours) to find out that Pep had passed away
- Following a spike in bile acids after COVID, bloods were checked **weekly** from 15 weeks and **biweekly** from 34 weeks
- Induction was scheduled for 37+4 (timing discussed **in collaboration** with Dr Arya)
- Dr Arya continued to communicate with us at our **two levels** and answered Heather's incessant **questions**/discussed the **latest research** with her in an **open** and **patient** way

Above and Beyond

*"This is what it **should** sound like when you deliver your baby"*

One of the midwives who delivered Pep, **Laura**, learned of our induction and switched her shifts around to be the one to induce and deliver Seth. She even worked an extra shift to make sure she was there for our first night with him, and had bought him a little rainbow ornament and balloons, which we treasure

His safe arrival clearly meant as much to her as it did to us

We want to take this opportunity to extend our heartfelt thanks to the whole team at Warrington Hospital, but especially to **Debbie**, **Dr Arya**, and midwives **Sarah** and **Laura** for helping our dream come true

Heather and Lloyd

Warrington and Halton Teaching Hospitals NHS Foundation Trust Minutes of the Trust Board Meeting – Meeting held in Public Wednesday 25 May 2022, Via MS Teams	
Present	
Steve McGuirk (SMcG)	Chairman
Simon Constable (SC)	Chief Executive Officer
Terry Atherton (TA)	Non-Executive Director & Deputy Chair
John Alcolado (JA)	Non-Executive Director
Jayne Downey (JD)	Non-Executive Director
Julie Jarman (JJ)	Non-Executive Director
Michael O'Connor (MOC)	Non-Executive Director
Cliff Richards (CR)	Non-Executive Director
Michelle Cloney (MC)	Chief People Officer
Paul Fitzsimmons (PF)	Executive Medical Director
Andrea McGee (AMcG)	Chief Finance Officer & Deputy Chief Executive
Dan Moore (DM)	Chief Operating Officer
Kimberley Salmon-Jamieson (KSJ)	Chief Nurse & Deputy Chief Executive
In Attendance	
Emma Blackwell (EB)	Service Manager Digestive Diseases – Endoscopy and Gastroenterology (in attendance for Agenda Item BM/22/05/48)
Adrian Carradice-Davids (ACD)	Associate Non-Executive Director
Dave Thompson (DT)	Associate Non-Executive Director
John Culshaw (JC)	Trust Secretary
Lucy Gardner (LG)	Director of Strategy & Partnerships
Jen McCartney (JMcC)	Head of Patient Experience & Inclusion
Pat McLaren (PMc)	Director of Communications & Engagement
Karen Smith (KS)	Ward Manager (in attendance for Agenda Item xxx)
Liz Walker (LW)	Secretary to the Trust Board (minute taking)
Observing Governors	
Dan Birtwistle (DB)	Staff Governor
Nathan Fitzpatrick (NF)	Public Governor
Sue Fitzpatrick (SF)	Public Governor
Akash Ganguly (AG)	Staff Governor
Adam Harrison (AH)	Patient Experience, Equality, Diversity, and Inclusion Manager & PROGRESS (LGBTQA+) Staff Network Chair
Steven Kilkenny (SK)	Public Governor
Norman Holding (NH)	Lead (Public) Governor
Kelly Jones (KJ)	Head of Strategy & Partnerships
Nichola Newton (NN)	Partner Governor
Public Observers	
No public observers were recorded in attendance	

Apologies	
No apologies for absence were noted	

Agenda Ref	Agenda Item
BM/22/05/48	**ENGAGEMENT STORY - JAG ACCREDITATION** EB provided members with the background regarding the Joint Advisory Group (JAG) who work with endoscopy services across the UK for patient care. For the accreditation, which takes place annually every five years, 133 standards are assessed for compliance and each organisation submits evidence onto the JAG website to demonstrate they are meeting best practice quality standards of the endoscopy service. EB talked about feedback report which was really positive and stated in relation to the service at WHH and Halton, "This was a highly effective patient-centred service that is exceptionally led by a dynamic team. Both sites operate to an equally exceptional standard and easily some of the highest standards seen in the UK." **A link to a video was also shared and would be circulated after the meeting.** DT congratulated the team on the accreditation, and it was good to see how the work takes place with user groups, patients, and patient groups. EB added there were a number of different ways in which patient feedback was collated, including a questionnaire, but not the Friends & Family, and this questionnaire asks of every aspect of their journey through the service, which is then reviewed at the Endoscopy User Group, and this is undertaken on a yearly basis and any issues addressed.. TA commented he had been a service user twice, and had an interesting experience, but as a whole it was a positive experience and was treated well from start to finish and was proud of the way the service was being delivered to the service users. JD added she had never seen feedback like this and congratulated the team on a job well done. SMcG noted some accreditations were more difficult than others and this one was particularly difficult. JA commented that the feedback from trainees going through the system would be helpful, in particular Diabetes service and asked as part of the service development were there plans to introduce nasal endoscopy. EB responded that the team work closely with C&M Endoscopy network and nasal was currently being reviewed and assessing patients who may be suitable for this procedure. SC also added his congratulations and well done to the team, and also more widely in relation to digestive diseases which had gone from strength to strength, being one of the more mature schemes with a set of high standards embedded within. It was good to see success stories and was a good platform to build on and

	springboard for those areas where we need to make improvements. **1. The Trust Board noted the Patient Story** **2. The Video would be circulated after the meeting.**
BM/22/05/49	**WELCOME, APOLOGIES AND DECLARATIONS OF INTEREST** The Chair welcomed everyone to the meeting. There were no apologies for absence received. It was noted a number of governors were in attendance and also colleagues in attendance who regularly present at the Shadow Board and thought appropriate to observe a full Trust Board meeting. SMcG mentioned the timeliness of papers and that it was not giving people enough time when receiving papers, a day or so prior to the meeting. It was noted the recruitment process for the replacement NED had concluded, with an appointment being made. It had been agreed at GNARC and would need approval through Council of Governors. SMcG thanked PF's son for supplying a wide range of cakes. **The Trust Board noted the welcome and comments.**
BM/22/05/50	**MINUTES AND ACTION LOG FROM THE PREVIOUS MEETING HELD ON 30 MARCH 2022** The minutes of the meeting held on 30 March were agreed as an accurate record and approved subject to minor amendments in relation to Infection Control and KSJ would provide the wording to be included. There were no actions to be reviewed. **The Trust Board approved the minutes of the meeting held on 30 March 2022.**
BM/22/05/51	**MATTERS ARISING** There were no matters arising in relation to the minutes or agenda.
BM/22/05/52	**CHIEF EXECUTIVES REPORT** SC noted the report as read and added he was still working on striving to produce a single side Dashboard highlighting key issues. CR added the interest in research facility as part of NED interviews was really high and it would be helpful to receive further information regarding this. SC added there would be a number of Board Seminars organised which would focus on a number of topics and would add research to the list. **The Trust Board noted the Chief Executive's Report.**
BM/22/05/53	**CHAIRMAN'S UPDATE**

	SMcG drew members attention to the launch of a number of key strategies which included midwifery and dementia, and a number of positive awards had been made. It was also noted the dashboard was useful to be included in the Chief Executive Report. SMcG added he had met the new Chair of the ICS and he had been invited to the to review issues and to discuss investment going forward, specifically for a new hospital. He had also been involved in supporting recruitment of NEDs across other trusts. There had been a visit to ED to sense check, with a walk around the new building to ensure the layout was right. Engagement with elected members continues and had also attended a Mayoral dinner. **The Trust Board noted the update and formally approved the recruitment as highlighted.**
BM/22/05/54	**COVID -19 PERFORMANCE SUMMARY AND SITUATION REPORT** **The Trust Board noted the report.**
BM/22/05/55	**INTEGRATED PERFORMANCE DASHBOARD & COMMITTEE ASSURANCE REPORT** SMcG commented on the layout of the Dashboard and identifying appendices and asked that everything be aligned for future reports. AMcG added this was the first time the report had been introduced in making data count and will pick up as an action and perhaps exclude the overview. SMcG asked that keys for the symbols be added for completeness. SC added more work could be done to simplify. ***Quality Dashboard*** ***Sepsis*** KSJ noted emergency screening was Amber but was on an upward trajectory in terms of screening timeframe as was the administration of antibiotics, with a lot of work being undertaken on education. Inpatient Sepsis metric was Red and further detail around this was at this time in April there were 15 patients audited to assure no harm, 2 patients were screened within 1.5 hours and 1 within 2 hours so just outside the required timeframe. Of 15 patients, 3 had antibiotics but screening not documented, 1 patient received antibiotics and no screening documentation on clinical decision to be given antibiotics. No patients came to harm, however there was still a lot of work to be done on collation and accuracy of data, and an overall sepsis action plan. New guidance was being reviewed to understand what this would mean for the Trust and would be shared at the next Quality Assurance Committee. JJ asked how pressure ulcers were being recorded as indicators moved from red to green and it would be easier to look at data by month, as gives a false impression if counting up yearly. KSJ noted that the team would look at in month variation from Cat 2 & 3 pressure ulcers as well as ongoing monthly and annual reporting.

KSJ added that wards which were more challenged would be highlighted and undertake monthly meetings to review actions plan, in particular Cat 3 were more concerning. In April there had been an increase in the number of patients being admitted and a root cause analysis showed this was due to long waits in ED and staffing levels.

There were three areas that had more pressure ulcers than they should, and training and leadership was in place as well as reviewing patient profiles.

MOC noted 62 day wait for cancer had moved from Red to Green, which was positive. He also asked about the impact of full capacity protocol on other areas of the Trust and whether it impacted on some of the indicators still showing as Red.

DM responded that full capacity protocol was a policy the Trust was expected to have in place as a control mechanism to restore the site once in an escalated state such as in Urgent Care and the issues with ambulance handover etc. It enables the Trust to bring teams together to work on a solution and could mean stepping down non urgent meetings, work in command control sense, in order to focus on making A&E a safe place. The impact on day-to-day operations can be in most parts stepping down meetings and redirecting resource. The Policy was not designed to be used intermittently but in particular times of pressure, however given the changing landscape of attendances and how the system was operating as a whole, the Trust had been on full capacity protocol for the last 4/5 months. Using it so often probably dilutes the message and was probably not as effective as it once was in dealing with the impact of pressures and the pandemic as well as attendance in A&E on a daily basis increasing. Therefore, the question arises as to whether it should be redesigned or even used at all, but at the moment the narrative from NHSE/I was that this should be continued to restore full capacity in the Trust.
There had been no impact on clinical services such as patient's requiring tests, or 2 week waits etc., and had maintained the services that need to remain.

JD noted the SPC charts gave a better idea of improvements making an impact and asked what was being done about Cat to make a difference, as currently nothing was in a steady state. Also, to look at medicines safety and reconciliation which has been in decline for some time, assumably down to sickness, but the impact on patient harm could be significant.

SC responded there had been deterioration in some of the inputs and KSJ added some were staffing issues which related back to the Deep Dive undertaken and reviewed at the Quality Assurance Committee which looked at harm profile which had increased between November and March. The QI work would be restarted and 10 wards in the main would be taken through as part of the QI campaign, along with training initiatives around pressure ulcers. Things were going well prior to Covid and then had to restart and stop, and this would be monitored closely when restarted.
In relation to medicines, there were some staffing issues and attendance numbers in A&E and would need to look at mitigation of those patients attending ED. SC would action the comment around potentially bespoke SPC refresher training.

PF noted in relation to medication reconciliation, as well as volume it was also about where they were in relation to MAU and having no pharmacy resource for

support, however recruitment had been approved to support this. The service would eventually move to a 7-day service, and where the gap was currently in reconciliation there was no increase in harm but was a risk area.

DT asked about patient falls, in particular was there a strategy around assisted technology and were there any patient monitoring systems in place. KSJ responded, in terms of specific technology there were falls sensory monitors which were ok but were not helpful around the QI work and for the wards in understanding the why, when, and how patients were falling and the reasons, in order to build support structures around this. The fall sensors were used in ward areas but don't have CCTV but did have individual carers and HCAs based in bays where there were a number of high-risk patients subject to falls.

There were 10 wards going through QI campaign, starting today which included Primary A and Acute wards, B14 and B19. AMcG suggested each indicator be looked at on the SPC chart where possible in order to review training exercise when it was undertaken.

JJ noted 1 in 6 patients had waited more than 12 hours in A&E. JD added in May had 11.36% patients seen within 72 hours and asked if it was worth reviewing the impact on delay on fractures, as this was a significant factor for recovery for patients as well as understanding the harm on patients. PF responded an electronic fracture clinic system had been introduced but would need to look at harms especially those with more complex fractures etc.

DM flagged up the impact in April from the Wave 6 perspective and that using B6 at Halton to provide additional beds and had impacted Month 1 and beg of Month 2 recovery. This was a national and regional impact and would look at restoration and recovery plans for 2022/23 and where we could make up ground for the rest of the year.

Staffing Report

MC reported sickness levels were high but were now reducing. 30 beds had been opened which had reduced but there was still significant issues with staffing and on IPR was showing as Amber. On a positive note, HCA vacancies were down to 12 and the focus on retention and registered nurse vacancies were down to 22, and retention would be a priority focus going forward. There had been problems in maintaining staff in HCA roles and there was a programme programme of work being undertaken across Cheshire & Mersey to look at rebanding from a 2 to a 3, and the Trust would be involved in this work. The Trust were working hard to move away from high-cost agencies, but still dipping into it as and when required. There was a comprehensive work force plan for the Therapies team, and this would be taken forward in next few weeks.

Maternity vacancies had reduced and four had been recruited this week.

SMcG asked about the sickness levels being high which related to a number of issues and how did this stack up with our peers, i.e., Christies and their approach to attendance management along with the same thing as the Children's hospitals. Also

how do we stack against standardised hospitals/trusts etc and who was best in class, as we do not seem to be making much progress, so this needs to be linked and flagged. JD asked if we were looking at NHSP managing agency to reduce the use of off framework staff and would this bring us up to or over establishment, and in specialist areas were there more staff off framework. KSJ responded there was a new process in place and were working with NHSP on fixed or agency costs with no use for off framework agencies other than in A&E and ITU areas. The high numbers had been due to sickness acuity and Covid.

DM noted discussions took place three times a week at ICS and Cheshire & Mersey levels to review performance data and staff absence was part of the review, broken by trusts within Cheshire & Mersey.

Assurance Report – Quality Assurance Committee

CR noted discussions regarding full protocol and 12-hour breaches and how do we keep the plates spinning, as with the current pressures it was really difficult and was not a normal state for the NHS.

SC added it was a fundamental problem underpinning all issues, as every initiative with partners needed to be tackled. CR responded there were mitigations for those we have control over.

People Dashboard

MC highlighted the areas of utilisation and comparison against other organisations and the work around supporting attendance. The Trust was not considered to be performing well and there was recognition around depravation and population health data, with sickness absence always on radar. A Deep Dive had been undertaken through Strategic People Committee and were working with NHSE/I and they put Christie on radar as best in class for supporting staff. As of today, sickness levels were 6.53% and Covid stood for 0.87% of the total, with long term sickness reducing. A dashboard would be developed to be presented in July which would show the data after the implementation of the supporting attendance policy.

SMcG added that an observation was that Execs need to look outside of the NHS for some exemplars and outside of the patch. It was not good news to hear the Trust were letting people go but was assured this was being managed appropriately.

DT commented it was good news regarding the recruitment of HCAs and had met with Cliff & Rebecca from Health and Wellbeing Board and received assurance work was underway in relation to health and wellbeing for staff. The reports mentions high rates of sickness in Estates and Facilities and asked if there was a risk around the ability to deliver on the capital programmes. MC responded it was mainly related to porters and domestic staff, and some of the wellbeing programmes would target these staff. TA concerns in capital programme around escalating costs, material availability.

MC added the hot topic at the Strategic People Committee had been to look at agency spend, which was an area where it was needed to be turned off as much as

possible. Mandatory training was a challenge, and support was needed to hold practical sessions in relation to resuscitation and moving and handling. There had also been challenges regarding undertaken appraisals.

Assurance Report – Strategic People Committee

JJ noted the committee had reviewed hot topics regarding retention and how to support the retention rates and also agency work and the complicated elements that sit behind it.

Sustainability Dashboard

AMcG noted the operational plan had been submitted in April with a deficit plan of £16.8m. As an ICS each organisation would take a share of the stretch improvement target yet to be allocated and was aware of the need to improve the £16.8m deficit to support the local system. Plan had not yet been accepted at this time, as part of the issue was around inflation which had been highlighted at a National Finance Director seminar by Julian Kelly. There was £1.5bn of funding allocated out to regions to allocate to the ICS which would then be allocated to the organisations within the ICS. Currently it was not known what the level of allocation would be received by the Trust, but was expected to improve the forecast, based on the allocation. It was thought the plan was likely to be announced nationally w/c 20 June and would await the timeframe with regards to submission to ICS and the internal approval route. It was also welcomed, about the drive nationally regarding agency costs and ceilings.

Table 2 in the report highlights elective recovery fund overview and noted activity plan was not achieved in April. With an allocation of £7m for the year, if we do not delivery activity as planned would lose 75% of the funding, and with an estimated non delivery of £700k for ERF had taken £500k out at Month 1.

The Capital Plan submitted to NHSE/I and was £2.3m short of CDEL, and was awaiting the outcome of the bid submitted, with further capital bids to be submitted. Contingencies would be used for emergencies only and also had externally funded capital. The Board were asked to note approval of a capital request of £19k through SORD. The CIP plans were ambitious and at this stage there was a slight shortfall in delivery for April, with some way to go in identifying further schemes. The risk had been highlighted in the Finance and Sustainability Committee with a number of actions highlighted in order to move at pace in order to identify these schemes.

SMcG asked about sickness levels and if this was a similar position across the patch and if it would have the same impact on recovery. AMcG responded she believed a number of organisations had difficulty in April therefore adding pressure on elective programmes, and if everyone underachieves was not sure what the outcome would be. DM added discussions were taking place at weekly COO meetings and would be shared with colleagues, but all were in the same position, with no outward communication at to what that might be but would be dependent on financial and activity plans.

	Assurance Report – Finance and Sustainability Committee TA highlighted the scale of the CIP challenge and governance arrangements had been implemented by the committee. There were potential capital risks to the programmes in relation to professional services and increased building materials costs. The Corporate Performance report would now be scrutinised at Clinical Recovery Oversight Committee and the situation regarding EPCMS procurement had been escalated to Private Board. ***Assurance Report – Audit Committee*** MOC highlighted that external auditors need to be resourced and not making unreasonable demands on the finance team. ***Assurance Report – Clinical Oversight Recovery Committee*** TA noted the reports circulated and highlighted the appropriateness to ensure the Board received escalation reports on harm reviews and increasing concern around staff sustainability over recovery programme, in particular 2 and 5 year horizons. – highlight appropriate ensure board escalates harm reviews and increasing concern around staff sustainability over recovery programme, in particular 2 and 5 year horizons. **The Trust Board discussed and noted the reports.**
BM/22/05/56	**MATERNITY UPDATE** KSJ noted the report for approval by Board and includes Ockenden and progress with Ockenden and in relation to CNST, how this was taken forward in the Trust. Successful in attainment of CNST standards which was positive and would be audited this year. Key metrics included stillbirth and neonatal. Work around ATAIN was positive and moving forward. Information relating to Lorenzo and Badgernet and the ongoing issues were highlighted, and different metrics aligned to Badgernet. From a national directive, Continuity of Care Plans were due to be submitted by 15 June and had been presented at Quality Assurance Committee for approval. AMcG asked about the claims element and if it was comparable and how do we sit externally. KSJ responded the Trust was comparable but not above peers. DT as how do we use lessons learnt. KSJ added this was feedback via various debriefs, learning circles, formal learning briefs, newsletters, sharing at handover, safety huddles and HSIB send in national lessons learned for sharing and take forward anything taken from Cheshire & Mersey to be shared. CR noted the Ockenden report and that with the Quality Assurance Committee (QAC) it was important to understand the maternity governance, which was complicated, and the Board should be informed of the Perinatal mortality rate

	which is now much more complicated. There is the potential requirement for a sense check in order for the Board to understand what Perinatal mortality rate means and this would help understand where the gaps were and to fill in. KSJ noted the Quality Assurance Committee would be expected to review this in detail and also the Maternity Safety Champions had undertaken further analysis which could be shared if required and suggested a Board Development day to discuss. SMcG added it would be useful to sub divide the topics at QAC and does not mean all the topics need to be discussed at Trust Board. **The Trust Board discussed and noted the update**
BM/22/05/57	**SIRO ANNUAL REPORT** TP summarised the report as SIRO for the Trust, and explained the role was a requirement of all NHS trusts as part of the wider information governance and cyber security. The report had been produced as part of evidence required and wanted to highlight two areas for noting. The report outlined the self-assessed performance, informed by MIAA review, against the standards in the DSPT. The Trust continues to perform well against the standards, continuously working to reduce risk and improve processes. The report includes a view on the standards which the Trust is unable to currently comply with, based on tighter national guidance aimed at raising the bar in the NHS in the area of Information Governance and Cyber Security. It is anticipated that the June 2022 DSPT submission to NHS Digital will reflect this position with a likely overall rating of "Approaching Standards" for 2021/22. Robust plans are being put in place to ensure all necessary actions will be completed to maximise the likelihood of the 2022/23 submission achieving a "Standards Met". In relation to training compliance, there was a need for wider support in order to achieve the 95% target for data security training, as a pre-requisite for achieving the standards met target for 2022/23. In relation to Cyber security, the Board were aware of the Russia/Ukraine potential cyber-attack, and this had been escalated to ensure the service is operating at heightened cyber threat level. Several high alert notifications had been received and had been responded to, along with the Killnet threat to shut down ventilators in hospitals. These were assessed as part of the regional cyber networks group and mitigations were in place for these risks. **The Trust Board noted the report.**
BM/22/05/59	**ENGAGEMENT YEAR END REPORT** PMcl presented and took the report as read. DT asked about the use of twitter and Facebook and that social media had become more critical during the pandemic and the engagement around what was happening within the Trust and the reach had been good. Hopefully, this would continue, and more people would start to engage on social media as we come out of the

	pandemic. TA added at the Shadow Board session in March the engagement dashboard had been discussed as part of the agenda raising questions around data and benchmarking against other trusts. The Trust was identified as top of the shop in terms of data and how it was communicated. DT also noted the excellent work around the Health and Well Being in Warrington and engagement with the public had been exemplary. **The Trust Board noted the report.**
BM/22/05/60	**NHS STAFF OPINION SURVEY** The report was taken as read and MC highlighted the survey had been presented later than usual due to the national timeframe. The questions had been set against the NHS people promise, with some questions dropped and some recalibrated to fit in with this. Of the 9 themes, 7 were above average, 1 just below which related to learning environment and specifically around appraisals and value of appraisal conversations. There had been some equality and diversity information shared with chairs of staff networks, to look at trends relating to protected characteristics. DT asked about health conditions and the score of 23.9% and whether this was recorded on staff records as would have expected to see a higher rate. ACD asked about how this data was correlated with RES data and NHSE document around diversity in leadership, and how this was pulled together to triangulate the data to process this going forward. MC added the Workforce Sub Committee undertake deep analysis of information along with chairs of staff networks and undertake deep dives to look at the impact of each group. Work takes place with those who do not declare and noted at the point of recruitment disability might not be evident. In terms of RES data and reporting, as an organisation the Trust had been asked to be pilot for it and on list for NHSE/I to evaluate out meaningfulness of the data. All triangulation takes place to ensure all areas are considered. SC noted in relation to age profile, there had been discussion to reach out to the younger workforce and the possibility of a Young People's Network in order to engage, as the workforce was now quite different to the historic workforce and something different needs to happen in order to ensure engagement. **The Trust Board noted the update.**
BM/22/05/61	**USE OF RESOURCES Q4** AMcG noted the Use of Resources report for Q4 and noted there had been two improvements since the last report, non-elective bed days and staff retention. The National data did not look right so was not confident the data was correct. Potentially Use of Resources could be starting up again in Q3 2022/23 and a section on high level findings from corporate benchmarking exercise and more detailed analysis would be included in the next report.

	The Trust Board noted the contents of the report.
BM/22/05/62	**BI MONTHLY STRATEGY UPDATE** LG highlighted there had been a refresh of clinical strategic priorities with CBUs being asked to review and feedback in due course. There had been some movement on some of the things mentioned, with a delay on the Shopping City handover now due to happen in September. The Breast Screening Consultation was now live and would close on 20th June, and there had been a successful engagement session relating to the Warrington Town Deal, and two sessions had taken place over the day, and it had given people an opportunity to input into the next stage of design. In relation to the Runcorn Town Deal Health & Education Hub, rapid progress was being made on the business case and would be presented to Board before formal submission. DT noted the Warrington wider estates review had been an immense piece of work and had covered a vast area of estates across Warrington. SMcG added it was a good opportunity for rationalisation of the estates in the borough. **The Trust Board noted the update.**
BM/22/05/63	**BOARD ASSURANCE FRAMEWORK** JC provided an update on key risks with no new risks added. Risk #1290 Brexit had reduced to 4 from 12 following discussion at the Risk Review Group and Quality Assurance Committee and deescalated to the departmental risk register. Risk #125 had been reviewed and agreed to reduce the rating from 16 to 15. Risk titles for #1372 electronic patient solution had been updated and would be reviewed and updated at the Finance and Sustainability Committee as things progress. There was discussion about how the review of the Risk Management Strategy would be undertaken and it agreed it would include a Board and training session taking place with members of staff and would be developed over the coming months. MOC talked about the number of risks on the BAF and that they need to reduce to a more manageable number which could mean encapsulation and merging of some of them. JC added there were a lot of risks specific to Covid and the aim was to reduce to 10 so would be closing and deescalating over the coming months. **The Board noted the updates.**
SUPPLEMENTARY PAPERS	
BM/22/05/64	**CODE OF GOVERNANCE COMPLIANCE & COMPLIANCE WITH LICENCE ANNUAL RETURN – COMPLETION OF CoS7** **The Board approved the Code of Governance Compliance and completion of CoS7.**
BM/22/05/65	**TERMS OF REFERENCE**

	The Terms of Reference were presented for approval in relation to the Strategic People Committee (SPC), Finance & Sustainability Committee (FSC) and Clinical Oversight Recovery Committee (CROC) **The Board approved the Terms of Reference for SPC, FSC & CROC.**
BM/22/05/66	**CYCLE OF BUSINESS – CLINICAL RECOVERY OVERSIGHT COMMITTEE (CROC)** **The Board approved the Cycle of Business for CROC.**
BM/22/05/67	**POLICIES** Polices relating to Social Media & Media Policy and Accessible Information Policy were presented for approval. The **Board approved the Social Media & Medical Policy and Accessible Information Policy.**
BM/22/05/68	**QUALITY ACCOUNT**
BM/22/05/69	**FINANCE & SUSTAINABILITY COMMITTEE – ANNUAL REPORT**
BM/22/05/70	**INFECTION & PREVENTION CONTROL (DIPC)**
BM/22/05/71	**INFECTION PREVENTION CONTROL – BOARD ASSURANCE FRAMEWORK**
BM/22/05/72	**LEARNING FROM EXPERIENCE REPORT Q4**
BM/22/05/73	**DIGITAL BOARD REPORT**
BM/22/05/74	**LEARNING FROM DEATHS REVIEW Q4**
BM/22/05/75	**WORKING WITH PEOPLE AND COMMUNITIES' STRATEGY**
BM/22/05/76	**PATIENT EXPERIENCE STRATEGY**
BM/22/05/77	**QUALITY STRATEGY ANNUAL UPDATE**
BM/22/05/78	**IPC STRATEGY**
BM/22/05/79	**GUARDIAN OF SAFE WORKING Q4 REPORT, SAFE WORKING HOURS JNRS DOCTORS IN TRAINING**
	The Trust Board noted Agenda items BM/22/05/68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78 and 79.
The Date and Time of the next Trust Board Meeting is Wednesday 27 July 2022	

Approved …… Dated ……

CHAIRMAN S McGUIRK

CMAST
Cheshire and Merseyside Acute and Specialist Trusts

Cheshire and Merseyside
Health and Care Partnership

CMAST Briefing

June 2022

NHS Cheshire and Merseyside Becomes a Statutory Organisation

NHS Cheshire and Merseyside has passed the significant milestone of becoming a statutory organisation on 1st July - a development which sees it become integral to the health and care for all of its 2.7 million residents.

Cheshire and Merseyside become one of 42 Integrated Care Systems (ICS) in the country, which are now on a legal footing. It also signals the closure of all nine Clinical Commissioning Groups (CCG) in Cheshire and Merseyside.

This marks a significant development in the way health and care needs for the population will be met; by reducing inequality in health and care provision and improving services and outcomes for people.

The creation of NHS Cheshire and Merseyside and a new statutory Integrated Care Partnership means that considerations and decisions can be made with partners, including Local Authorities, while retaining local influence and decision making within the nine "Places" of Cheshire and Merseyside, which cover the Local Authority boroughs. Unlike previous NHS re-organisations, this marks a fundamental shift in the alignment and work of health and care services across the region and is the single largest change to health and care in decades. Integrated care is designed to improve patient experience and outcomes by bringing services closer together and reducing unfair differences in availability and outcomes for people across Cheshire and Merseyside – thereby helping reduce health inequalities.

CMAST Development

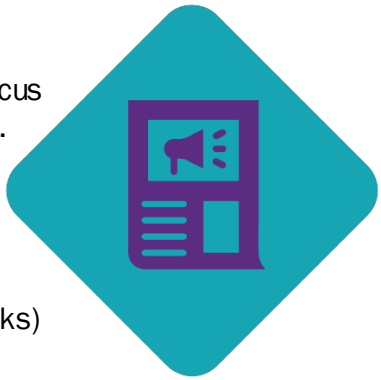
Further to the last update on the CEO and Chairs' development session, which took place on 6th May, engagement has taken place with CMAST governance leads and company secretaries on the emerging proposals to formalise the CMAST Leadership Board. This will take shape through development of a Joint Working Agreement and establishing a Committee in Common which can be used to develop and underpin shared decision making when and as appropriate.

Proposals are expected to be reviewed by the CMAST Leadership Board at the end of July following further engagement with CMAST's governance leads. The summer will then be used to brief and orientate boards through CEOs, Chairs and your local teams, with a view to securing agreement on these important foundations during September.

Planning is currently underway to host a briefing session and workshop, for non-executive directors of boards across both collaboratives and the ICB in early August focused on system working, shared challenges and government changes to the way in which trust boards are expected to work and be accountable going forward. We recognise August can be a tricky time, however, the timeliness of this discussion with the recently established ICB and the live consultations affecting boards feels appropriate.

Elective Recovery and Transformation Programme

Long Waits:



The trusts have been working incredibly hard to clear the long waits, with a key focus on the 104 weeks. At the end of July, the C&M system declared 34 breaches in total.

- 77 P6's (patients who have opted to wait longer for their treatment)
- The end of July position risks equates to 33 patients, (although not all trusts have confirmed their position)
- Plans are in place to treat the majority of the long wait patients in July..
- All Trusts aim to maintain a zero 104-week position in July (aside from P6 risks)

Theatre Productivity:

- The theatre productivity dashboard has now been commissioned to be updated on a monthly basis, providing 3 views
    - In-session productivity (a list was run and staffed)
    - Fallow theatre session opportunities
    - OPCS* level benchmarking marking, linked to high volume low complexity (HVLC) procedures
- Sessions have been arranged with every trust to review opportunities and data
- HVLC opportunities pack has been developed for every trust, to be circulated w/c 4th July
- Ongoing virtual training sessions are still available
- May performance saw a 2% increase in utilisation and average cases per 4-hour session increase by 0.1 (across the whole systems for largest surgical specialities)

Outpatient Transformation:

The programme is gaining pace, with the development of a formal oversight group and the ability to monitor activity through the new transformation dashboard. Key highlights include:

- Patient Initiated Follow Up (PIFU) activity is rising steadily, up to 1.4% of all outpatient attendances and doubling from 0.7% in the previous month. Specialty mapping has been undertaken to further inform scale up, sharing of best practice and gap analysis.
- The next C&M wide Outpatient Transformation Network meeting is planned for 7th July and will focus on plans for the new Personalised Follow Up ambitions. A case study will be shared by LUFT, who have demonstrated a successful model of digital PIFU.

Other Project Highlights:

- Gastroenterology referral pathways piloted in North Mersey will be rolled out across C&M, and a joint project with the endoscopy programme is currently being established. The work seeks to standardise pathways, improve processes for patients, and support GPs in managing diagnostics.
- A joint undertaking with the C&M Cardiac Network has seen the formation of a NW Cardiology PIFU Special Interest Group, chaired by LHCH. This group will look to offer direction and implementation guidance for clinicians and trusts who are rolling out PIFU in a cardiac sub-specialty.
    - Specialist advice has been incorporated into the C&M tele-dermatology roll out, support is currently being offered to ensure that it is also part of the new electronic eye care referral system to further enhance the offer into primary care.
    - Work is also underway with the personalised care programme and digital programme to ensure that transformational changes are sustainable and result in measurable benefits for patients.

*The Office of Population Censuses and Surveys Classification of Interventions and Procedures

Clinical Pathways Programme

The Clinical Pathways Programme was launched in April 2022. The programme brings a structured and methodical process to review specialties and develop improvement plans at a whole pathway level.

Simon Constable is the programme SRO and Sir David Henshaw is the Chair sponsor.

A formal governance structure has been established with a leadership team – reporting into the Elective Recovery and Transformation Programme Board. Clinical leads for each of the prioritised specialties are working with the dedicated project team, through the clinical networks, to build on existing work, and identify, prioritise, and implement opportunities for improvement to support longer term transformation.

Programme Highlights

Work is underway in **orthopaedics,** with engagement of trust level clinical and operational leads, along with other key stakeholders across the Cheshire and Merseyside system. A current state analysis has been developed to support the first workshop, held on 15th June, with the aims of:

- Gaining consensus on the current challenges facing orthopaedics across Cheshire and Merseyside
- Agreeing what good looks like for orthopaedics and establishing principles to adhere to going forward
- Defining how to work practically together as a system – establishing short term commitments and a structure for decision making.

Further engagement is taking place with trust clinical and operational leads and system key stakeholders to discuss the outputs from the workshop and take forward key actions and next steps.

Diagnostics Programme

Community Diagnostics Centres (CDCs)

- C&M CDCs are delivering a run rate of 110,000 tests per year, which is the highest level in the Northwest.
- We have 5 CDCs operational, with plans submitted for an additional 4 CDCs, regional approvals have been received.

Performance

A monthly diagnostic performance report has been developed. We ask that all trusts review this data at board level. The report will be shared with Chief Operating Officers and Chief Executives and others who would find it useful.

March Performance Headlines:

- C&M ICS is ranked 16th out of 42 ICSs for diagnostic waiting time performance.
- C&M ICS is delivering the 3rd highest levels of diagnostic activity, as the ICS with the 4th largest population, this is excellent and we are aiming for more!
- C&M diagnostic activity levels have increased each month since Jan 2022.
- 75,685 C&M patients are waiting for a diagnostic test, 1/3 of these patients have been referred for non-obstetric ultrasound.
- C&M MRI activity levels are now greater than pre-pandemic levels. 88% of MRI patients were seen within 6 weeks.

This data allows us to identify issues, opportunities, and review health inequalities such as the rates of activity and waiting times between places. Among a range of plans to help address inequalities, we are working to facilitate mutual aid, a number of our trusts have provided support including:

- Alder Hey have agreed to provide mutual aid for paediatric patients who are waiting for CT, MRI and ultrasound.
- Liverpool Heart and Chest agreed to support organisations with MRI capacity.
- The Walton Centre agreed to provide mutual aid with imaging capacity.
- East Cheshire Trust is supporting neighbouring trusts with endoscopy capacity.
- C&M performance will be monitored at an aggregate level, as such we will be increasingly seeking collaboration, to ensure we achieve the highest standards.

Endoscopy

- Broadgreen have launched a service for patients to receive a transnasal gastroscopy, this regional service is helping to reduce waiting times and patients are reporting that this new method for scoping is less uncomfortable than traditional methods.

Workforce

- Business case to establish a C&M system wide bank for the diagnostic workforce is in final stages subject to agreement by organisations. Implementation is planned from November 2022 onwards.

Echocardiography

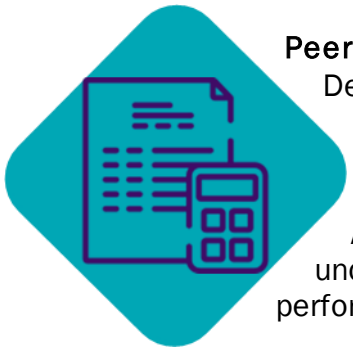
- All trusts have been asked to ensure that appointment slots are in line with the British Society of Echocardiography Guidelines which recommends an echo should take 40-45 minutes. C&M activity levels have increased month on month since Dec 2021.

Urgent and Emergency Care – Gold Command

- Overall COVID occupancy and COVID G&A occupancy continues to increase across Trusts, COVID occupancy is at 12% for C&M. New COVID admissions and inpatient diagnoses have risen significantly in recent weeks.
- C&M Acute Trust COVID related staff absence has increased from previous weeks to 23% of all sickness absences.
- G&A bed occupancy remains very high; on average 96% or greater for C&M.
- Trusts continue to report high numbers of long lengths of stay patients and patients no longer meeting the criteria to reside.
- All Acute Trusts remain pressured in terms of continued high occupancy and front door demand impacting on flow from Emergency Departments. Trusts additionally reporting large numbers of A&E attendances, high patient acuity leading to high conversion rates of admissions from A&Es; some admissions exceeding discharges and discharges coming up late in days, impacting further on existing UEC pressures. Crowding in Emergency Departments leading to episodes of corridor care. Trusts are additionally reporting staffing gaps and challenges and high agency staff usage.
- Weekly monitoring of UEC pressures continues to take place through the Chief Operating Officers' Group and led by the ICB Designate Director of Performance & Planning.

Finance and Collaboration at Scale

After numerous iterations a C&M financial plan was submitted on 20th June with a deficit of £30m; this figure is linked to costs associated with the opening of the new Royal Hospital. The financial plan contains significant levels of risk and financial performance at month 2 is a higher risk than planned deficit, this is linked to delays in delivering efficiency plans and costs of recovery.



Peer Scrutiny Process

Deficit organisations are subject to extensive and robust review, these meetings are in progress with themes and learning collected.

Aligning Incentives and Delivery

An agreement has now been made to cap the loss of income linked to elective underperformance at the level of total ERF. This will manage risk, the impact on over performance will need to be modelled and reviewed.

Capital Prioritisation

Organisations have been notified of their backlog maintenance and capital priorities funding. C&M retains a risk reserve for in year issues.

Impact of specialised commissioning roadmap

C&M strategy directors are reviewing the impact of the transition to delegation, Jon Develing is leading this work. The initial focus is on:

- Transfer of specialised expertise from NHSE to the ICB
- Alignment with networks
- Alignment with pathway development work
- Mapping whole pathway's funds, flow, and readiness to amend pathways
- Impact of PPI

The majority of local specialised services are referred to in the delegation schedule and this is being worked through locally and through the Federation of Specialist Hospitals.

Collaboration at Scale

MIAA will report back this month on the major opportunities for C&M based on benchmarking, Model Hospital, ERIC returns and GIRFT. This will inform the prioritisation of the workstreams.

Principles and Rules of Engagement

It is important that Providers sign up to an underlying set of principles about how we operate as a collaborative. This work focussing on Boards' and governance is being supported by Hill Dickinson and from this a more detailed set of principles will need to be developed. Jane Tomkinson is the SRO for this work, Jane is seeking volunteer CEOs to join a task and finish group to progress this in advance of key decision points, e.g., investment priorities and CoS schemes.

Other Workstreams

Now that the C&M financial plan has been established, other workstreams will commence via Claire Wilson, ICB CFO and CFO community, with oversight from CMAST board and workstream SROs.

Chair Sponsorship

A meeting was held on 21st June with Ian Haythorn-Thwaite, Chair Sponsor, who is currently reviewing the workplans, briefings and ToRs. A follow up session with Kathy Doran and Karen Bliss will be set up in late July/August. Thanks to all for the offers of help.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM 22/07/88 i**	
SUBJECT:	**IPR Development & NHSE Oversight Framework Update**	
DATE OF MEETING:	27th July 2022	
AUTHOR(S):	**Dan Birtwistle, Deputy Head of Contracts & Performance**	
EXECUTIVE DIRECTOR SPONSOR:	**Andrea McGee, Chief Finance Officer & Deputy Chief Executive**	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x
	SO3 We will.. Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#224** Failure to meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience. **#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. **#115** If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm **#134** Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. **#1125** Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust introduced Statistical Process Control (SPC) charts onto the Trust IPR in 2019 and introduced Making Data Count SPC Assurance & Variation icons in May 2022. Following on from the Trust Board Development Session on 29 June 2022 a number of developments in relation to the IPR are underway or proposed and these are outlined in this paper.	

	In addition, an updated version of the NHSE/I Oversight Framework was published on 27 June 2022 with a new set of oversight metrics. The Trust is awaiting further guidance from NHSE/I in the form of a technical specification to understand how these metrics are reported/monitored. This paper outlines the current proposal for mapping of these metrics.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Note the immediate changes made to the IPR from this month's Board Report. 2. Note the establishment of a working group to implement future changes identified in this paper. 3. Note the suggested training groups. 4. Note the alignment of the new NHSE Oversight Framework metrics.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Executive Team Meeting		
	Agenda Ref.	IPR Development and NHSE Oversight Framework Update		
	Date of meeting	19th July 2022		
	Summary of Outcome	Support		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	IPR Development & NHSE Oversight Framework Update	AGENDA REF:	BM 22/07/88 i

1. BACKGROUND/CONTEXT

The Trust introduced Statistical Process Control (SPC) charts onto the Trust IPR in 2019 and introduced Making Data Count SPC Assurance & Variation icons in May 2022. Following on from the Trust Board Development Session on 29 June 2022 a number of developments in relation to the IPR are underway or proposed and these are outlined in this paper.

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2. KEY ELEMENTS

2.1 Agreed changes made to the IPR to reflect "Making Data Count" from the July 2022 Board Report

In 2019/20, Statistical Process Control (SPC) charts were introduced to the Trust IPR Board Report. It was agreed by the Trust Board in March 2021 to introduce "Making Data Count" Assurance and Variation icons to further build on the SPC charts. Following the Trust Board Development Session on 29 June 2022, it was agreed to remove the RAG ratings from the IPR. In order to achieve this, a number of further changes to the IPR were necessary as follows:

- The IPR front cover now describes the IPR metrics in relation to "Assurance" and "Variation" in place of RAG ratings.
- Appendix 1 which contained the RAG matrix with the movement arrows has been removed.
- The RAG pie charts on the front of the dashboard have been removed.
- The RAG boxes on the dashboard have been changed to include a target rather than RAG criteria with all colours removed. The target is based on the previous "Green" position e.g., if the Trust had to achieve 95% in order to be Green, the target states 95%.
- Assurance & Variation icons have been included on the charts.
- SPC statistical narrative has been included on the dashboard.

2.2 Future developments to the IPR

Due to the scale of development required, it will take several months in order to make the necessary changes in order to fully realise the benefits of SPC/Making Data Count. Future developments to take place over the remainder of 2022/23 are:

- Consideration to redesign the dashboard to group inter-dependant indicators together.
- Developments to SPC charts to automatically highlight variation using the blue/orange/grey colour scheme recommended by NHSE/I. Tools are available from

NHSE/I and technical development will be required in order to incorporate these into existing reports/dashboards.

- Ability to reset process limits (which changes the Mean, Upper and Lower control limits on the SPC chart) where significant step changes have taken place (e.g. COVID-19). This will require technical development as well as the agreement of governance processes (to agree when limits should be changed).

2.3 Future requirements around non-IPR reporting

In order to ensure consistency across reporting, a review will take place in order to understand the reports across the Trust which will need to be updated from Board to Ward as follows:

Level 1: Trust IPR

Level 2: Committee Reporting

- Quality Committee - utilises Quality Dashboard from Trust Board IPR.
- Finance & Sustainability Committee – Finance dashboards to be reviewed by the Finance Directorate.
- Clinical Recovery Oversight Committee – The Corporate Performance Report to be reviewed by the Information Team/Operations Directorate.
- Strategic People Committee – to be reviewed by the People Directorate.

Level 3: CBU IPR/QPS Reporting

- The CBU level IPR will be developed to include SPC Charts/Icons which will feed into the QPS (Quality, People, Sustainability Care Group Reviews).

Level 4: Local Reporting

- Introduction of SPC for any reporting which may feed into the IPR. An example provided by NHSE/I was RTT which is split into a range of specialities, whist the high level RTT indicator may be within process control limits (common cause variation), the specialities may not. SPC is already utilised within several nursing and quality reports.

In order to progress the development work required, it is proposed a time limited working group is established. This group will be chaired by the Deputy Chief Finance Officer, with a clear terms of reference and will report into the Executive Team until all the actions are completed. The Executive Team has been asked to provide nominations of individuals who they would like to attend the working group.

2.4 Training/Education Sessions for "Making Data Count"

NHSE/I offers a series of bite sized live webinars for staff at all levels and disciplines across the organisation in order to gain a better understanding of SPC and "Making Data Count". It is important that colleagues across the organisation are comfortable with and understand SPC/Making Data Count in order to maximise the benefits and to make the necessary improvements. In addition, it would be beneficial to have consistency across the Trust regarding presentation of intelligence. There are 7 steps within the training process. **Table 1** provides a suggestion by groups of staff who may find each step useful.

Step 1: Introduction to SPC (covered in the Board Development Session)
Step 2: Using our SPC tools
Step 3: Writing narrative

Step 4: Tips to convert your colleagues
Step 5: Comparisons & Benchmarking
Step 6: Improvement Methods
Step 7: Triangulation of Data

Table 1: SPC/Making Data Count Proposed Training Groups*

	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7
Executive Directors	X		X				
Non-Executive Directors	X						
Deputy/Associate Directors	X		X		X	X	
Performance Managers or Quality Improvement Managers or Data Managers (All Trust)	X	X	X	X	X	X	X
Digital Analytics Contracts, Performance & Commercial Development Team	X	X	X	X	X	X	X
Senior Corporate Managers (HR, Finance, Nursing/Governance)	X		X		X	X	
Senior Operational/Clinical Managers (Care Group/CBU)	X		X		X	X	
All Staff who work with data/information	X						

* as stated, Table 1 highlights the suggested training groups, however individuals can attended any sessions that they will find useful.

2.5 2022/23 NHSE Oversight Framework published in June 2022

The 2022/23 NHSE Oversight Framework was published on 27 June 2022. The fundamental principles of the 2021/22 framework remain unchanged with the main difference being the removal of CCGs and the role of ICBs in the oversight process.

A new set of oversight metrics have been published alongside the framework. An initial mapping of these metrics can be found in **Appendix 1**. The Trust is awaiting the technical specification which sits alongside the matrix and explains exactly how each metric is measured and the source of the data. There are 36 oversight metrics which relate to providers, however only 32 of these are relevant to the Trust.

3. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the immediate changes made to the IPR from this month's Board Report.
2. Note the establishment of a working group to implement future changes identified in this paper.
3. Note the suggested training groups.
4. Note the alignment of the new NHSE Oversight Framework metrics.

Appendix 1: NHSE Oversight Framework – 2022/23 Trust Oversight Metrics

Key:

	Current indicator on the IPR/Reported to the Trust Board via another method
	To be included as an indicator on the IPR

Oversight Theme	NHS Long Term Plan/People Plan Area	Measurement Name (Metric)	Suggested Action/Status
Quality of care, access and outcomes	Elective Care	Total patients waiting more than 52, 78 and 104 weeks to start consultant-led treatment	52 & 104 week waiters are included on the IPR. Presentational amendment to include 78 week waiters is required.
		Total elective activity undertaken compared with 2019/20 baseline	Included on the IPR.
		Total diagnostic activity undertaken compared with 2019/20 baseline	Included on the IPR.
	Cancer	Total patients waiting over 62 days to begin cancer treatment compared with baseline	Included on the IPR.
		Proportion of patients meeting the faster cancer diagnosis standard	Included on the IPR.
		Total patients treated for cancer compared with the same point in 2019/20	New IPR Indicator Required – awaiting technical specification in order to ensure accuracy of reporting.
	Outpatient Transformation	Outpatient follow-up activity levels compared with 2019/20 baseline	Total Outpatient activity compared with 2019/20 levels is included on the IPR. Presentational amendment to also included follow up activity levels only.

	Urgent & Emergency Care	Proportion of ambulance arrivals delayed over 30 minutes	Included on the IPR.
		Proportion of patients spending more than 12 hours in an emergency department	Included on the IPR.
	Safe, High Quality Care	Summary Hospital -level Mortality Indicator	Included on the IPR.
		National Patient Safety Alerts not completed by deadline	Included on the IPR.
		Potential under-reporting of patient safety incidents	Incident reporting is included on the IPR, however the technical specification will be reviewed once published to ensure this triangulates.
		Overall CQC Rating	Reported to the Trust Board in line with CQC inspections.
		Acting to improve safety - safety culture theme in the NHS staff survey	Reported to the Trust Board in line with annual staff survey results.
		Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Included on the IPR.
		Clostridium difficile infection rate	Included on the IPR.
		E. coli bloodstream infection rate	Included on the IPR.
Preventing ill health and reducing health inequalities	Reducing inequalities	Performance against relevant metrics for the target population cohort and five key clinical areas of health inequalities1	Will require a new IPR indictor. Awaiting technical specification from NHSE/I to ensure accuracy of reporting.
	Prevention and long term conditions	Proportion of acute or maternity inpatient settings offering smoking cessation services	Will require a new IPR indicator. Awaiting technical specification from NHSE/I to ensure accuracy of reporting.
		Proportion of patients who have a first consultation in a post -covid service within six weeks of referral	Will require a new IPR indicator. Awaiting technical specification from NHSE/I to ensure accuracy of reporting.
	Screening, vaccination and immunisation	Proportion of people over 65 receiving a seasonal flu vaccination	Unclear if this is relevant to the Trust – awaiting technical specification from NHSE/I.
Leadership and capability	Leadership	Aggregate score for NHS staff survey questions that measure perception of leadership culture	Reported to the Trust Board in line with annual staff survey results.

		CQC well -led rating	Reported to the Trust Board in line with CQC inspections.
Finance and Use of Resources	Finance	Financial efficiency - variance from efficiency plan	Included on the IPR (CIP).
		Financial stability - variance from break - even	Included on the IPR.
		Agency spending	New IPR indicator required.
People	Looking after our people	Staff survey engagement theme score	Reported to the Trust Board in line with annual staff survey results.
		Staff survey bullying and harassment score	Reported to the Trust Board in line with annual staff survey results.
		Leaver Rate	Included on the IPR (Retention & Turnover).
		Sickness absence rate	Included on the IPR (Supporting Attendance).
	Belonging to the NHS	Proportion of staff in senior leadership roles who are from a) a BME background or b) are women	Reported annually via WRES report.
		Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	Reported to the Trust Board in line with annual staff survey results.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/07/88 ii**	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	27th July 2022	
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director Kimberley Salmon-Jamieson, Chief Nurse, Director of Infection Prevention & Control and Deputy Chief Executive Michelle Cloney – Chief People Officer Andrea McGee - Chief Finance Officer and Deputy Chief Executive Dan Moore - Chief Operating Officer	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will.. Work in partnership with others to achieve social and economic wellbeing in our communities.	x x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#224** Failure to meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience. **#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. **#115** If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm **#134** Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. **#1125** Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance.	

EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust has 79 IPR indicators which have been placed into the following categories based on SPC/Making Data Count "Assurance" principles and performance over the last 6 months: Consistently passes the target: 15 Consistently fails the target: 25 Inconsistently passes/fails the target: 13 No SPC/Not enough datapoints: 26 There was 1 case of MRSA reported in June 2022. The Trust has not met the target for Medicines Reconciliation within 24 hours or the Friends and Family Test within ED/UEC for the last 6 months. Sepsis Screening and Antibiotics Administration within ED remains challenging. The Trust has not met the standard for Diagnostic 6 Weeks, RTT 18 & 104 Weeks, A&E 4 Hour & 12 Hour, Cancer 14 Days, Breast Symptomatic, Cancer 62 Day Urgent, Ambulance Handovers within 15, 30 & 60 minutes, Discharge Summaries within 24 hours, Outpatient Activity Delivered Remotely or Fracture Clinic 72 hours. The Trust has submitted a £6.1m deficit plan for 2022/23. This includes achieving £7.9m ERF (Elective Recovery Fund), £15.7m CIP and £3.0m Income efficiency target. The month 3 position is £4.56m deficit year to date which is £0.2m worse than plan.			
PURPOSE: ***(please select as appropriate)***	Information	Approval X	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Note the Capital requests of £51k approved as an emergency by the Chief Finance Officer & Deputy Chief Executive. 2. Approve the capital requests for corporate offices (£14k) and fluoroscopy room (£16k) 3. Approve the increase to the capital contingency for the VAT rebate. 4. Approve the changes to the capital plan to manage the current Capital Department Expenditure Limit (CDEL) shortfall. 5. Note the contents of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**			
	Agenda Ref.			

	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report	AGENDA REF:	BM/22/07/88 ii

1. BACKGROUND/CONTEXT

All 79 IPR indicators have been placed into one of several "Assurance" categories and one of several "Variation" categories as determined by the principles of Statistical Process Control and Making Data Count.

Appendix 1 details "Making Data Count" icons and data in relation to Statistical Process Control (SPC).

The Integrated Performance Dashboard (**Appendix 2**) has been produced to provide the Trust Board with assurance in relation to the delivery of all Key Performance Indicators (KPIs) across the following areas:

- Quality
- Access and Performance
- Workforce
- Finance Sustainability

Following the Board Development Session on 29 June 2022, Red/Amber/Green ratings have been removed from the IPR. A separate paper provided to the Trust Board outlines these changes and proposals for future changes to the IPR.

2. KEY ELEMENTS

Table 1 contains the number of IPR indicators in each Making Data Count "Assurance" category. **Table 2** contains the number of IPR indicators in each Making Data Count "Variation" category.

Table 1: Assurance Categories*

		Quality	Access & Performance	People	Finance & Sustainability
	**Consistently Passes the Target (based on the last 6 months)**	7	4	3	1
	**Consistently Fails the Target (based on the last 6 months)**	4	13	7	1
	**Inconstantly Passes/Fails the Target**	6	3	2	2
	**No SPC/Not Enough Datapoints/Not Applicable**	10	12	1	3
Total		27	32	13	7

*based on the last 6 months performance.

Table 2: Variation Categories

		Quality	Access & Performance	People	Finance & Sustainability
	**Common Cause Variation**	9	16	6	2
	**Special Variation of an Improving Nature**	2	1	1	1
	**Special Variation of a Concerning Nature**	3	4	3	0
	**No SPC/Not Enough Datapoints/Not Applicable**	13	11	3	4
Total		27	32	13	7

Descriptions of each KPI are available in **Appendix 3**. Further detail around interpretation of Statistical Process Control (SPC) charts and "Making Data Count" icons can be found in **Appendix 4**.

Quality

Assurance

There are 4 Quality indicators which are consistently failing the target, these are:

- 10. Medication Reconciliation within 24 hours – the Trust achieved 57.00% in June, against a target of 80.00%
- 18. Friends & Family Test (Urgent & Emergency Care) – the Trust achieved 70.00% in June, against a target of 87.00%.
- 21. Sepsis Screening (Emergency Patients) – the Trust achieved 76.00% in June, against a target of 90.00%.
- 23. Sepsis Antibiotics Administration (Emergency Patients) – 74.00% in June, against a target of 90.00%.

There are 6 Quality indicators which are inconsistently passing/failing the target, these are:

- 3. Healthcare Acquired Infections – MRSA – the Trust reported 1 case of MRSA in June, against a target of 0.
- 7. VTE Assessment – the Trust achieved 92.75% in June, against a target of 95.00%
- 12. Staffing Care Hours Per Patient Day – the Trust achieved 7.2 CHPPD in June, against a target of 7.9 CHPPD.
- 15. NICE Compliance – the Trust achieved 91.15% in June, against a target of 90.00%. Therefore, this target was achieved in June.
- 22. Sepsis Screening (Inpatients) – the Trust achieved 91.00% in June, against a target of 90.00%. Therefore, this target was achieved in June.
- 24. Sepsis Antibiotics Administration (Inpatients) – the Trust achieved 82.00%, against a target of 90.00%.

SPC Assurance cannot be determined for the following indicators which have failed to meet the target in month:

- 11. Staffing Average Fill Rate – the average staffing fill rate for all four groups combined was 87.75% in June, against a target of 90.00%.
- 26. Acute Kidney Injury – there were 164 AKIs reported in the Trust in June, against a target of less than 143 AKIs (reported in May).

Variation

There are 3 Quality indicators which are indicating special cause variation of a concerning nature, these are:

- 3. Healthcare Acquired Infections - MRSA
- 7. VTE Assessment
- 10. Medicines Reconciliation within 24 hours

Access and Performance

Assurance

There are 13 Access & Performance indicators which are consistently failing the target, these are:

- 28. Diagnostics 6 Week Waiting Times – the Trust achieved 85.47% in June, against a target of 99.00%.
- 29. Referral to Treatment – 18 Weeks – the Trust achieved 66.18% in June, against a target of 92.00%.
- 30. Referral to Treatment – 104 Week Waits – there were 14 patients waiting over 104 weeks in June, against a target of 0. Whilst this indicator doesn't comply with the target, this is in line with the Trusts 2022/23 plan.
- 31. A&E Waiting Times – 4 hours – the Trust achieved 69.53% in June, against a target of 95.00%.
- 35. Cancer 14 Days – the Trust achieved 88.04% in May, against a target of 93.00%.
- 36. Breast Symptoms 14 Days – the Trust achieved 91.30% in May, against a target of 93.00%.
- 41. Cancer 62 Day Urgent – the Trust achieved 83.33% in May, against a target of 85.00%.
- 43. Ambulance Handovers within 15 minutes – the Trust achieved 42.89% in June, against a target of 65.00%.
- 44. Ambulance Handovers within 30 minutes – the Trust achieved 66.19% in June, against a target of 95.00%.
- 45. Ambulance Handovers within 60 minutes – the Trust achieved 75.21% in June, against a target of 100%.
- 46. Discharge Summaries (24 Hours) – the Trust achieved 91.96% in June, against a target of 95.00%.
- 55. % Outpatient Activity Delivered Remotely – the Trust achieved 11.44% in June, against a target of 25.00%.
- 56. % Patients seen in the Fracture Clinic within 72 hours – the Trust achieved 36.20% in June, against a target of 95.00%.

There are 3 Access & Performance indicators which are inconsistently passing/failing the target, these are:

- 37. Cancer 28 Day Faster Diagnostic Standard – the Trust achieved 75.24% in May, against a target of 75.00%. Therefore, this target was achieved in June.
- 42. Cancer 62 Days Screening – the Trust achieved 88.89% in May, against a target of 90.00%.
- 47. Discharge Summaries (7 Days) – there were 0 discharge summaries not sent within 7 days to meet the requirement, against a target of 0. Therefore, this target was achieved in June.

SPC Assurance cannot be determined for the following indicators which have failed to meet the target in month:

- 31. A&E Waiting Times (12 Hours) – the Trust achieved 15.73% in June, against a target of 2.00% or less.
- 52. COVID-19 Recovery (Inpatient/Daycase) – the Trust achieved an average of 82.24% for inpatient/daycases combined in June, against a target of 104%.
- 53. COVID-19 Recovery (Diagnostics) – the Trust achieved an average of 62.61% across all diagnostic modalities combined in June, against a target of 104%.
- 54. COVID-19 Recovery (Outpatients) – the Trust achieved 92.96% of outpatient activity in June, against a target of 104%.

Variation

There are 4 Access & Performance indicators which are indicating special cause variation of a concerning nature, these are:

- 29. Referral to Treatment – 18 Weeks
- 31. A&E Waiting Times – 4 Hours
- 51. Super Stranded Patients
- 55. % Outpatient Activity Delivered Remotely

PEOPLE

Assurance

There are 7 People indicators which are consistently failing the target, these are:

- 60. Supporting Attendance – the Trust achieved 6.25% in June, against a target of 4.20% or less.
- 61. Welcome Back Conversations – the Trust achieved 55.45% in June, against a target of 85.00%.
- 62. Recruitment Time to Hire – time to hire average days was 77 in June, against a target of 65 days or less.
- 63. Vacancy Rate – the Trust achieved 10.89% in June, against a target of 9.00% or less.
- 64. Retention – the Trust achieved 83.17% in June, against a target of 86.00%.
- 65. Turnover – the Trust achieved 16.06% in June, against a target of 13.00% or less.
- 66. Bank & Agency Reliance – the Trust achieved 18.23% in June, against a target of 9.00% or less.

There are 2 People indicators which are inconsistently passing/failing the target, these are:

- 67. Monthly Pay Spend – monthly pay spend was £19.7m in June, against a budget of £20.1m. Therefore this target was achieved in June.

- 72. PDR Compliance – the Trust achieved 60.41% in June, against a target/trajectory of 79.00%.

SPC Assurance cannot be determined for the following indicator which has failed to meet the target in month:

- 70. Safeguarding Training – the Trust achieved 70.67% in June, against a target/trajectory of 83.00%.

Variation

There are 3 People indicators which are indicating special cause variation of a concerning nature, these are:

- 61. Welcome Back Conversations
- 63. Vacancy Rates
- 64. Retention

Finance and Sustainability

Assurance

There is 1 Finance & Sustainability indicator which is consistently failing the target, this indicator is:

- 76. Better Practice Payment Code – the Trust achieved 92.00% (cumulative), against a target of 95.00%.

There are 2 Finance & Sustainability indicators which are inconsistently passing/failing the target, these are:

- 73. Trust Financial Position – the Trust recorded deficit as at the end of month 3 of £4.56m against a planned deficit of £4.34m.
- 75. Capital Spend – the Trust capital spend as at the end of month 3 was £3.24m against a plan of £3.16m.

SPC Assurance cannot be determined for the following indicator which has failed to meet the target in month:

- 79. Cost Improvement Programme (Recurrent Forecast) – the Trust is forecasting a recurrent CIP achievement of £2.1m, against a full year target of a minimum of £6.5m.

Variation

There are no Finance & Sustainability indicators which are indicating special cause variation of a concerning nature.

The Income and Activity Statement for June 2022 is attached in **Appendix 5**.

The 2022/23 operational plan has been re-submitted. The Trust has agreed a control total of £6.1m deficit with Cheshire & Merseyside ICB.

Table 3 details the Trust activity performance for June 2022 against the draft baseline.

Table 3: Trust activity performance for June 2022 versus draft baseline

POINT OF DELIVERY	M3 PLAN	M3 ACTUALS	M3 VARIANCE	M1-3 PLAN	M1-3 ACTUALS	M1-3 VARIANCE
Daycase	2,235	2,245	10	6,866	6,523	(343)
Elective	309	189	(120)	950	625	(326)
Outpatient First Attendance	4,743	4,557	(186)	14,162	14,229	67
Outpatient Procedure	5,859	4,082	(1,777)	17,389	13,365	(4,024)
Totals	**13,146**	**11,073**	**(2,073)**	**39,367**	**34,742**	**(4,625)**
% OF 19/20 ACTIVITY	104.0%	87.6%	(16.4%)	104.0%	91.8%	(12.2%)

During June 2022, all elective activity with the exception of day cases, has underperformed against plan. The year to date position shows an under performance against all elective activity except for outpatient first attendances which are slightly above plan.

Performance points to note for June 2022:

Elective

The main factors which have contributed to the variation against the activity plan include:

- 84 elective cases were cancelled in June (71 day cases and 13 inpatient cases) due to lack of available beds/site pressures, an increased level of sickness related to COVID-19 and the management of arthroplasty patients at CSTM.
- B4 remains on reduced capacity as 6 of the beds remain escalated due to challenges with flow.
- The endoscopy unit having increased level of sickness which resulted in limited additional activity being undertaken.
- A high number cancer operations were required due to an increase in referrals which are typically longer cases which reduces cases per session, this was mainly in General Surgery and Breast.
- A number of additional and core theatre sessions were not able to be scheduled due to continued high sickness levels in June due to COVID-19. This was particularly apparent in anaesthetics which resulted in lists being taken down.

Outpatients Procedure/First Attendance

Of the 186 outpatient first attendance variance and the 1,777 outpatient procedure variance:

- A high DNA rate (10.11% in June 2022) and short notice cancellations (11.2% in June 2022) – this is being addressed through the transformation groups.
- High levels of staff sickness and annual leave.

Cash

At the end of June there is a cash balance of £38.0m. Creditors relating to 2021/22 are still to be paid as invoices have not been received for costs accrued at year end. This includes trade creditors (£6.1m) and a timing difference in the payment of capital creditors (£5.2m). There has also been additional income from contracts (£2.3m) and additional VAT recovery (£0.4m).

CIP

At the end of June, the Trust has delivered a CIP of £2.1m against a plan of £2.1m. A total of £14.1m has been identified (£7.4m as at May) leaving £1.6m to be identified during the year. The £3.0m efficiency requirement has been profiled into Q4 in line with when monies are expected to be available, however the Trust is awaiting a response to bids for additional bed capacity.

Of the £14.1m CIP identified, £5.7m (40%) is high risk and £12.1m is non-recurrent (85%). A further risk is the requirement in the plan to achieve an income target of £3.0m. This has been profiled into Q4. The identified CIP and income target, together with the high risk CIP equates to £10.3m.

Whilst there has been a large improvement in scheme identification since May, further work is required to firm up plans and the associated values and the Executive Team is overseeing these plans in the weekly executive meeting with the care groups and corporate leads.

Capital Programme

In June 2022, the Trust Board approved an increase of £1.1m to the Capital Programme from £12.8m to £13.9m (including schemes that may need to be extended over an 18 month period) following confirmation of successful bids for other capital items. To date CDEL of £12.5m has been allocated to the Trust. To manage the shortfall of £1.4m it is recommended a proportion of the contingency is utilised and several schemes are moved to 2023/24 and these schemes can be brought forward to 2022/23 if additional CDEL is received from further bidding process. **Table 4** outlines this proposal.

Table 4: Capital Proposal

Suggestions	Value £m
Defer element of backlog maintenance to 2023/24	0.6
Defer Doctors Mess Room to 2023/24	0.1
Reduce Contingency to £0.4m	0.4
Other Slippage (TBC)	0.3
TOTAL	**1.4**

In the Operational Plan, the Trust was required to submit a capital plan based on CDEL allocated to date. In addition, the Trust was asked to include strategic capital bids to support elective recovery and diagnostic services and any capital to be funded from grants. **Table 5** provides a breakdown of the capital plan, assuming the Board approved the proposal in **Table 4.**

Table 5: Capital Plan Summary by Category

	Plan FY	Plan YTD	Actual YTD	Variance against Plan YTD
	£'000	£'000	£'000	£'000
Estates	7,000	2,693	2,695	- 2
IM&T	2,113	206	235	- 29
Medical Equipment	3,000	142	235	- 93
Contingency	381	-	- 44	44
Sub total	12,494	3,041	3,121	- 80
External Funded	10,187	117	117	-
Total	22,681	3,158	3,238	- 80

Emergency requests for £51k have been approved by the Chief Finance Officer & Deputy Chief Executive in June 2022. The Trust Board is asked to approve additional capital requests to be funded from contingency of £30k. **Table 6** outlines the emergency changes and proposed changes to the contingency.

Table 6: Balance of contingency fund as at 30 June 2022

DETAIL	£'000	£'000
Contingency balance start of month 3		**818**
Proposed changes in month		
Emergency request		
Microtome and Slidewriter Addendum (Now Emergency Request) - 61617	-3	
Replacement Hot Water Cylinder CSTM - 61618	-13	
Boiler Block 1 - 61619	-21	
Dishwasher A3 - 61615	-6	
Boiling Pan - 61613	-8	
Sub Total		**-51**
VAT rebate		**9**
Contingency as at end of month 3		**776**
Requested at CPG 15 July 2022		
Corporate Offices HR Reception Desk	-14	
Fluoroscopy Room - addendum for unplanned asbestos work	-16	
		-30
Contingency as at 15 July 2022 (if supported)		**746**

Appendix 6 contains the updated Capital Programme.

The Trust Board is asked to:

- **Note the Capital requests of £51k approved as an emergency by the Chief Finance Officer & Deputy Chief Executive.**
- **Approve the capital request for corporate offices (£14k) and fluoroscopy room (£16k).**
- **Approve the increase to the capital contingency for the VAT rebate.**
- **Approve the changes to the capital plan to manage the current Capital Departmental Expenditure Limit (CDEL) shortfall.**

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The KPI's that are underperforming are managed in line with the Trust's Performance Assurance Framework.

4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:

- Finance and Sustainability Committee
- Audit Committee
- Quality & Assurance Committee
- Strategic People Committee
- Clinical Recovery Oversight Committee

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the Capital requests of £51k approved as an emergency by the Chief Finance Officer & Deputy Chief Executive.
2. Approve the capital requests for corporate offices (£14k) and fluoroscopy room (£16k).
3. Approve the increase to the capital contingency for the VAT rebate.
4. Approve the additional capital spend of £30k
5. Approve the changes to the capital plan to manage the current Capital Department Expenditure Limit (CDEL) shortfall.
6. Note the contents of this report.

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

- Special Cause Variation of a improving nature.
- Common Cause (Normal Variation).
- Special Cause Variation of a concerning nature.
- Consistently passes the target*
- Inconsistently passes and fail the target*
- Consistently fails the target*

*based on the last 6 datapoints/months

		Latest				Previous		Assurance
	QUALITY	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
1	Incidents (over 40 days old)	0	0	Jun-22	L	0	May-22	P
2	Duty of Candour (serious incidents)	100.00%	100.00%	Jun-22		100%	May-22	P
3	Healthcare Acquired Infections - MRSA	0	1	Jun-22	H	0	May-22	?
4	Healthcare Acquired Infections – CDI	Less than 37 for 2022/23	0	Jun-22		5	May-22	No SPC
5	Healthcare Acquired Infections – Gram Negative (E.coli)	Less than 57 for 2022/23	5	Jun-22		6	May-22	No SPC
6	Healthcare Acquired Infections - COVID-19 Outbreaks	N/A	5	Jun-22	No SPC	2	May-22	No SPC
7	VTE Assessment	95.00%	92.75%	Jun-22	L	94.19%	May-22	?
8	Inpatient Falls & Harm Levels	20.00% annual reduction based on 590 in 2021/22	42	Jun-22		52	May-22	No SPC
9	Pressure Ulcers (Total)	10.00% reduction based on 91 in 2021/22	7	Jun-22		11	May-22	No SPC

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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10	Medication Safety (24 Hours)	80.00%	57.00%	Jun-22	L	58.00%	May-22	F
11	Staffing – Average Fill Rate (Combined)	90.00%	87.75%	Jun-22	No SPC	90.91%	May-22	No SPC
12	Staffing – Care Hours Per Patient Day	7.9	7.2	Jun-22		7.5	May-22	?
13	Mortality ratio - HSMR	N/A	86.28	Jun-22	No SPC	86.48	May-22	No SPC
14	Mortality ratio - SHMI	N/A	98.50	Jun-22	No SPC	100.16	May-22	No SPC
15	NICE Compliance	90.00%	91.15%	Jun-22		91.48%	May-22	?
16	Complaints (open over 6 months)	0	0	Jun-22		0	May-22	P
17	Friends & Family – Inpatients & Day cases	95.00%	97.00%	Jun-22	No SPC	97.00%	May-22	P
18	Friends & Family – ED and UCC	87.00%	70.00%	Jun-22	No SPC	72.00%	May-22	F
19	Mixed Sex Accommodation Breaches (Non ITU Breaches Only)	0	0	Jun-22	No SPC	0	May-22	P
20	Continuity of Carer	51.00%	84.90%	Jun-22	H	79.30%	May-22	P

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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21	Sepsis - % screening for all emergency within 1 hour.	90.00%	76.00%	Jun-22	No SPC	83.00%	May-22	F
22	Sepsis - % screening for all inpatients within 1 hour.	90.00%	91.00%	Jun-22	No SPC	86.00%	May-22	?
23	Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis.	90.00%	74.00%	Jun-22	No SPC	83.00%	May-22	F
24	Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis.	90.00%	82.00%	Jun-22	No SPC	90.00%	May-22	?
25	Ward Moves between 10:00pm and 06:00am	N/A	71.00	Jun-22	No SPC	N/A	N/A	No SPC
26	Number of Hospital Acquired Acute Kidney Injuries	Less than previous month	164	Jun-22	No SPC	143	May-22	No SPC
27	Number of CAS Alerts Actions Breached	0	0	Jun-22		0	May-22	P

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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*based on the last 6 datapoints/months

		Latest				Previous		Assurance
	ACCESS & PERFORMANCE	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
28	Diagnostic Waiting Times 6 Weeks	99.00%	85.47%	Jun-22	H	85.21%	May-22	F
29	RTT - Open Pathways (18 Weeks)	92.00%	66.18%	Jun-22	L	68.76%	May-22	F
30	RTT – Number of Patients Waiting 104+ Weeks	0	14	Jun-22	Common	22	May-22	F
31	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge.	95.00%	69.53%	Jun-22	L	70.50%	May-22	F
32	A&E Waiting Times – ICS Trajectory	Trajectory TBC for 2022/23			No SPC			No SPC
33	A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2.00% or less	15.73%	Jun-22	No SPC	14.04%	May-22	No SPC
34	Average time in department ED (mins)	N/A	321	Jun-22	No SPC	307	May-22	No SPC
35	Cancer 14 Days*	93.00%	88.04%	May-22	Common	82.92%	Apr-22	F
36	Breast Symptoms 14 Days*	93.00%	91.30%	May-22	Common	91.67%	Apr-22	F

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37	Cancer 28 Day Faster Diagnostic*	75.00%	75.24%	May-22		70.07%	Apr-22	
38	Cancer 31 Days First Treatment*	96.00%	100.00%	May-22		100.00%	Apr-22	P
39	Cancer 31 Days Subsequent Surgery*	94.00%	100.00%	May-22		100.00%	Apr-22	P
40	Cancer 31 Days Subsequent Drug*	98.00%	100.00%	May-22		100.00%	Apr-22	P
41	Cancer 62 Days Urgent*	85.00%	83.33%	May-22		82.14%	Apr-22	F
42	Cancer 62 Days Screening*	90.00%	88.89%	May-22		57.14%	Apr-22	
43	Ambulance Handovers within 15 minutes	65.00%	42.89%	Jun-22		51.88%	May-22	F
44	Ambulance Handovers within 30 minutes	95.00%	66.19%	Jun-22		72.69%	May-22	F
45	Ambulance Handovers within 60 minutes	100%	75.21%	Jun-22		81.19%	May-22	F
46	Discharge Summaries - % sent within 24hrs	95.00%	91.96%	Jun-22		90.72%	May-22	F
47	Discharge Summaries – Number NOT sent within 7 days	0	0	Jun-22		0	May-22	

Statistical Process Control - Assurance & Variation

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48	Cancelled Operations on the day for a non-clinical reasons	Please note: Validation for this indicators was in progress at the time of reporting.						No SPC
49	Cancelled Operations– Not offered a date for readmission within 28 days							No SPC
50	Urgent Operations – Cancelled for a 2nd time	0	0	Jun-22		0	May-22	P
51	Super Stranded Patients	Trajectory TBC for 2022/23	128	Jun-22	H	142	May-22	No SPC
52	COVID-19 Recovery Elective (Inpatient/Daycase) - (Average)	104%	82.24%	Jun-22	No SPC	83.46%	May-22	No SPC
53	COVID-19 Recovery Diagnostic Activity - (Average)	104%	62.61%	Jun-22	No SPC	70.20%	May-22	No SPC
54	COVID-19 Recovery Outpatient Activity	104%	92.96%	Jun-22	No SPC	93.91%	May-22	No SPC
55	% Outpatient Appointments delivered remotely	25.00%	11.44%	Jun-22	L	12.02%	May-22	F
56	% of Patients seen in the fracture clinic within 72 hours	95.00%	36.20%	Jun-22		67.45%	May-22	F
57	Advice & Guidance (A&G) Activity Levels	N/A	493	Jun-22	No SPC	482	May-22	No SPC
58	Patient Initiated Follow Up (PIFU) Activity Levels	N/A	23	Jun-22	No SPC	22	May-22	No SPC

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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		Latest				Previous		
	WORKFORCE	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	**Assurance**
59	% of zero-day length of stay admissions (as a proportion of total)	N/A	62%	Jun-22	No SPC	66%	May-22	No SPC
60	Supporting Attendance	4.20%	6.25%	Jun-22		6.31%	May-22	F
61	Welcome Back Conversations	85.00%	55.45%	Jun-22	L	64.31%	May-22	F
62	Recruitment Time to Hire (Days)	65	77	Jun-22		76	May-22	F
63	Vacancy Rates	9.00%	10.89%	Jun-22	H	10.80%	May-22	F
64	Retention	86.00%	83.17%	Jun-22	L	83.16%	May-22	F
65	Turnover	13.00%	16.06%	Jun-22		16.26%	May-22	F
66	Bank & Agency Reliance	9.00%	18.23%	Jun-22		16.74%	May-22	F
67	Monthly Pay Spend (Contracted & Non-Contracted)	£20,115,931.00	£19,686,211.50	Jun-22		£20,275,151.71	May-22	?

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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68	Core/Mandatory Training	85.00%	85.30%	Jun-22	H	85.36%	May-22	P
69	Role Specific Training	85.00%	91.62%	Jun-22	No SPC	91.50%	May-22	P
70	Safeguarding Training	83.00%	70.67%	Jun-22	No SPC	70.71%	May-22	No SPC
71	% Workforce carrying out an Apprenticeship Qualification	2.30%	2.43%	Jun-22	No SPC	2.67%	May-22	P
72	PDR Compliance	79.00%	60.41%	Jun-22		60.44%	May-22	?

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		Latest				Previous		Assurance
	FINANCE & SUSTAINABILTY	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
73	Trust Financial Position £m (Cumulative)	-4.34	-4.56	Jun-22		-4.15	May-22	?
74	Cash Balance £m	23.80	38.00	Jun-22	H	40.47	May-22	P
75	Capital Programme Spend £m (Cumulative)	3.16	3.24	Jun-22	No SPC	1.60	May-22	?
76	Better Payment Practice Code (Cumulative)	95%	92%	Jun-22		92%	May-22	F
77	Use of Resources Rating	Please note: This indicator is currently suspended. The Trust is awaiting further guidance from NHSE/I						No SPC
78	Cost Improvement Programme – Performance (Recurrent and Non-recurrent delivered) £m	2.10	2.10	Jun-22	No SPC	1.20	May-22	No SPC
79	Cost Improvement Programme – Forecast (Recurrent) £m	6.50	2.10	Jun-22	No SPC	N/A	N/A	No SPC

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
System Oversight Framework
Care Quality Commission
Risk Register
Trust Strategy

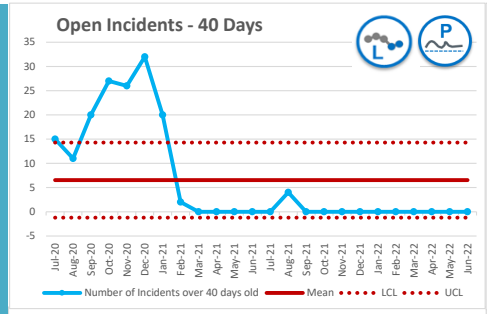
Quality Improvement - Trust Position

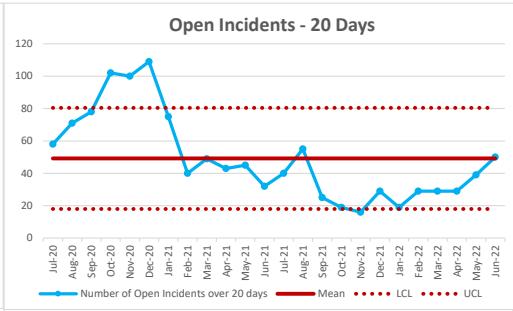
Appendix 2

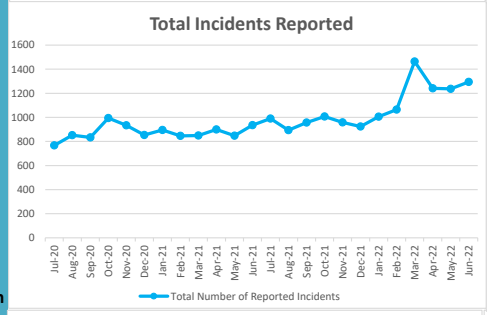
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
1. Incidents **Target: ZERO Open incidents outside 40 day timeframe and ZERO Never Events**				

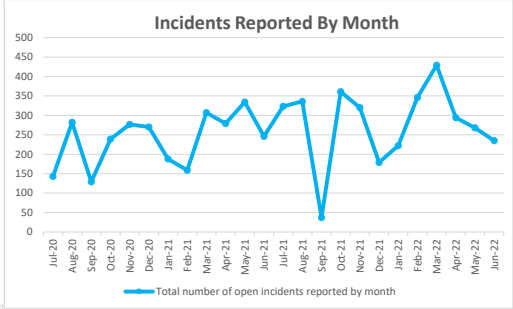
SOF CQC

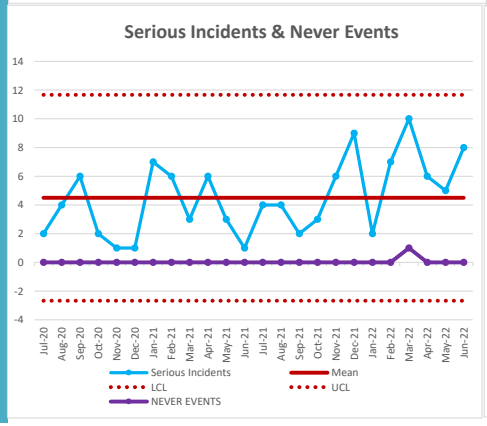
There were 0 incidents open over 40 days old and 39 incidents open over 20 days old. These have all had a first review and have been sent to the relevant department, no concerns noted with those over 20 days.

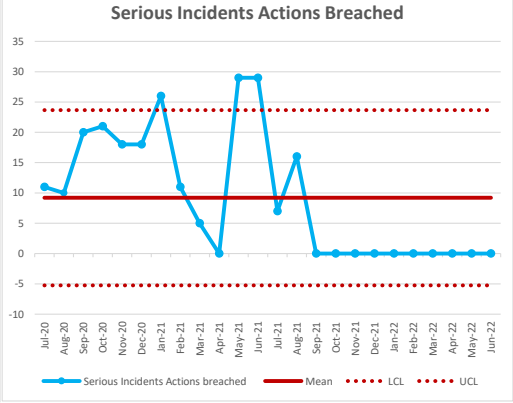












Assurance: The Trust consistently passes the target.

Variation: There is special cause variation of a improving nature.

Incident reporting remains within range. The culture of incident reporting is positive and the steady increase noted coincides with increased operational pressures.

The Report to Improve Campaign continues with close weekly monitoring of incident reporting Trust wide, CBU and speciality specific. A weekly governance dashboard is overseen by the Executive Team monitoring trends of reporting.

No variance from the last reporting period. There are 0 overdue 40-day incidents.

Weekly CBU monitoring supports with timely escalation to the Associate Director of Governance to ensure the position of zero open incidents over 40 days is maintained.

There were 8 serious incidents reported in June 2022. An increase of 3 when compared to May 2022 (5). Medical Care - Incorrect diagnosis, A6 - delay to treatment, ED - delay to treatment, A6 - pressure ulcer and a Fall at the hospital entrance.

System pressures remain a contributory factor with ongoing discussion with system partners to reduce the number of superstranded patients. Learning from incidents continues to be shared at Governance Meetings with oversight of the Care Groups. A Trust wide learning framework is being devised to support wider learning alongside Quality Improvement Programmes. Work is being undertaken alongside Therapy Teams regarding deconditioning.

No variance compared to the last reporting period. There were 0 breached Serious Incident actions in June 2022.

Weekly monitoring continues with appropriate escalation to the CBU leads.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:

System Oversight Framework — SOF

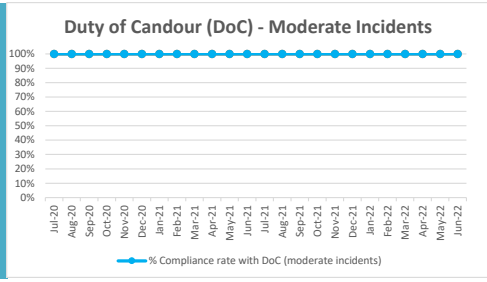
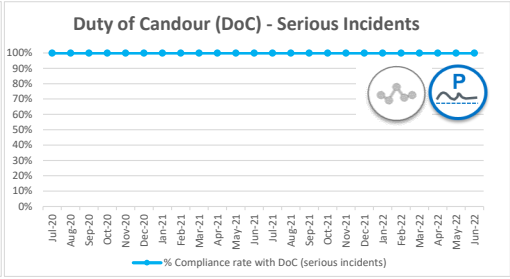
Care Quality Commission — CQC

Risk Register — RR116

Trust Strategy — S

Quality Improvement - Trust Position

Appendix 2

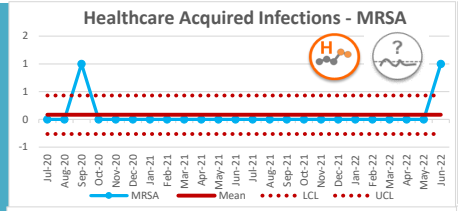
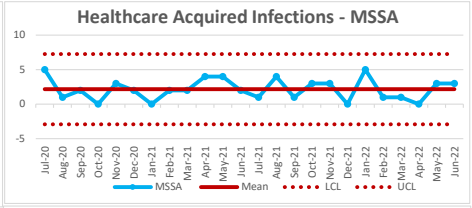
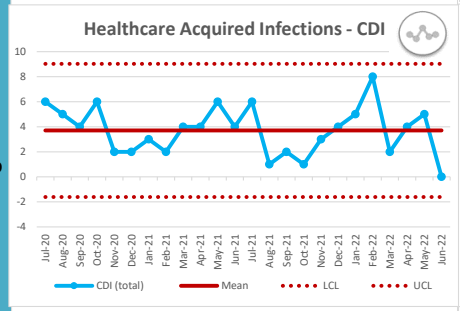
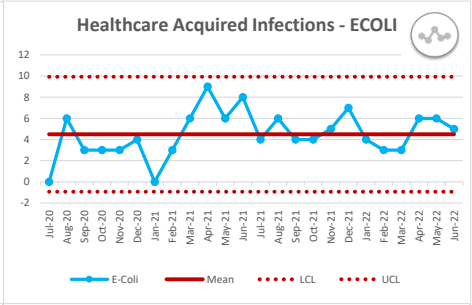
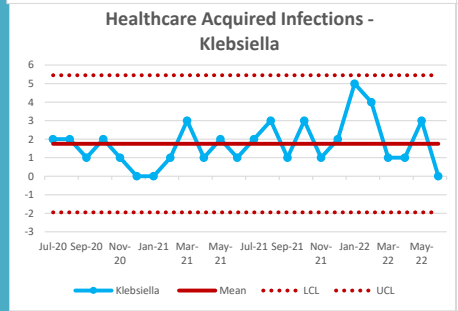
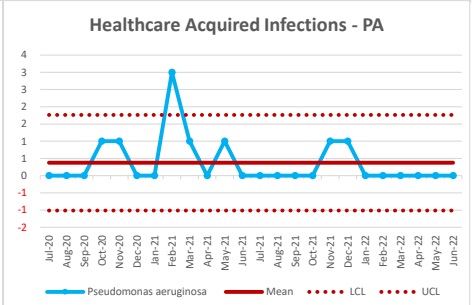
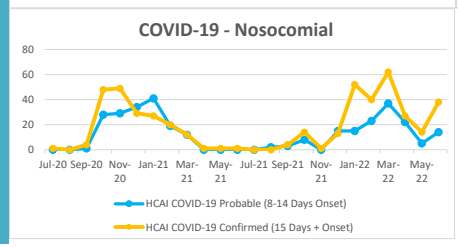
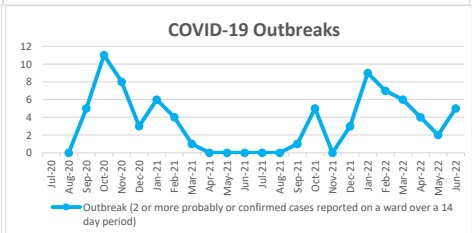
Trust Performance	Trend		Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
2. Duty of Candour **Target: 100%** CQC **The Trust achieved 100% for Duty of Candour in month.**			**Assurance: The Trust consistently passes the target.** **Variation: Common Cause (Normal) variation.**	**There is no variance, the Trust remains 100% compliant.**	**Robust weekly monitoring is undertaken by the Patient Safety Manager to ensure compliance is maintained.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
System Oversight Framework
Care Quality Commission
Risk Register
Trust Strategy

Quality Improvement - Trust Position

Appendix 2

Trust Performance	Trend		Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
3. Healthcare Acquired Infections (MRSA) **Target: ZERO**			**(MRSA) Assurance:** The Trust inconsistently passes/fails the target. **(MRSA) Variation:** Special Cause Variation of a concerning nature.	Unknown source for the MRSA bacteraemia infection. Missed opportunity for taking the blood culture sample.	Action plans are in place for the prevention of HCAIs with a focus on invasive device management. Additional training provided on IV device management to areas identified with opportunities for improvement.
4. Healthcare Acquired Infections (CDI) **Target: Less than 37 -annual**			**(CDI) Assurance:** N/A Annual Target **(CDI) Variation:** Common Cause (Normal) variation.	Higher incidence of C. difficile across the northwest and 18 acute Trusts were above last years set threshold. Increase in antibiotic prescribing associated with respiratory infections & COVID-19.	Continue with the current CDI prevention strategy and also look at use of proton pump inhibitor medication with the Gastroenterology Team. Continue focus on environmental hygiene and use of HPV. Hand Hygiene promotion strategy for patients and revise education plan for staff. Continue review of root cause analysis investigations to identify learning. Awareness raising campaign in production.
5. Healthcare Acquired Infections (Ecoli) **Target: less than 57 - annual** **(Klebsiella)** **Target: Less than 19 - annual** **(PA)** **Target: Less than 6 - annual**			**(ECOLI) Assurance:** N/A Annual Target **(ECOLI) Variation:** Common Cause (Normal) variation.	The change in the apportionment rule has increased the number of GNBSI cases apportioned to the Trust. Work has been carried out with the Quality Academy to implement improvements in patient care.	Quality Academy support is in place with 8 wards engaged in a collaborative. Focus areas include hydration, continence management, care of urethral catheters, hand hygiene and UTI detection and management. The UTI pathway was launched at Grand Round in May 2022. An audit of Klebsiella spp. cases identified missed blood culture sampling opportunities and care of urinary catheter as areas for care improvement.
6. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks (No Target)			**N/A - No target.**	The Trust has seen a reduction in the number of patients being admitted with COVID-19.	Close liaison with the operational teams to support patient placement. Risk assessments in place to prevent vulnerable patient contact with Covid exposed patients. Outbreak Control Groups convened to manage outbreaks to prevent transmission to additional patients and staff.

MRSA: 1 Case in May, 1 Case YTD.
CDI: 0 Cases in June, 9 Cases YTD on trajectory.
E-Coli: 5 Cases in June, 17 Cases YTD - 3 cases over trajectory.
Klebsiella: 0 Cases in June, 4 Cases YTD - on trajectory.
P. aeruginosa: 0 Cases in May, 0 Cases YTD. 1 case under trajectory
COVID-19:
41 day 8-14 cases probable healthcare associated cases YTD
79 day 15+ cases definite healthcare associated YTD

5 COVID-19 outbreaks

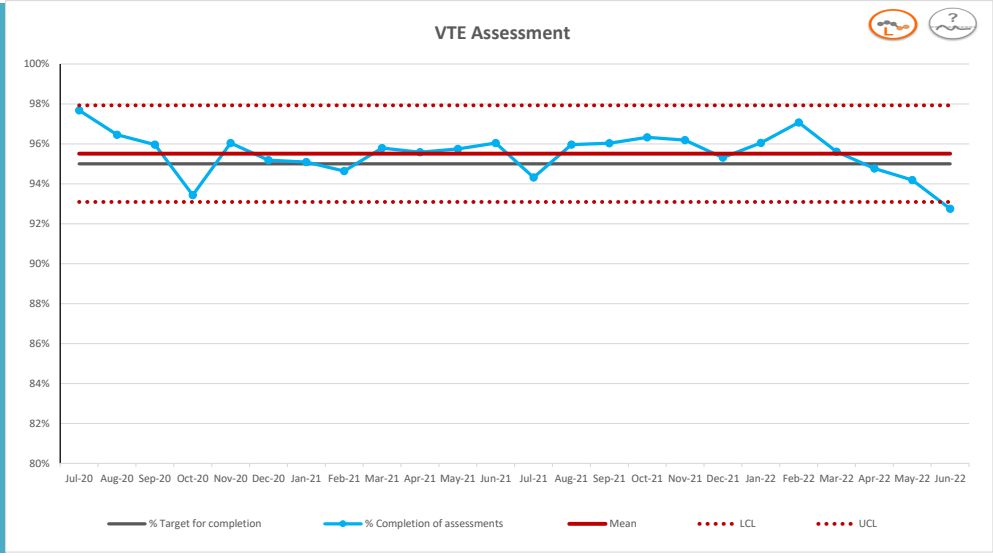
RR1275

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
System Oversight Framework
Care Quality Commission
Risk Register
Trust Strategy

Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
7. VTE Assessment Target: 95% (quarterly position)	The Trust achieved below the required target at 92.75% for VTE assessments at from the start of the financial year in June 2022.		Assurance: The Trust inconsistently passes/fails the target. Variation: Special cause variation of a concerning nature.	This is the second consecutive month failing to reach the required target 95% in this financial year since May 2022. This is due to introduction of Badger net EPR system in the maternity unit causing incomplete data capture of all VTE risk assessments (RA) completed to date since the launch in May 2022. Progress is being made to rectify the situation.	Monthly CBU VTE RA compliance data has been distributed to all CBU governance meetings since April 2022 on monthly basis for further improvement plans from CBU. All doctors responsible for non-completion of VTE RA risk assessment within 14 hours are emailed directly to raise the awareness of the importance of the need to complete VTE RA before prescribing thromboprophylaxis. Plans are in progress to adopt the current WHH ward round proforma for a standardised Trust wide approach which includes VTE RA as a safety check list with an aim to re-launch in August 2022.

Quality Improvement - Trust Position

Appendix 2

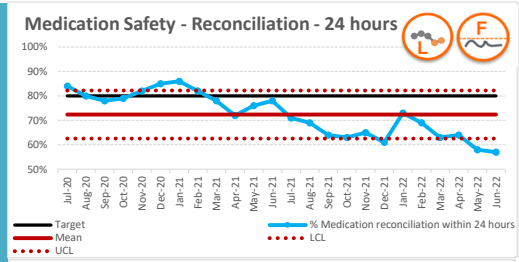
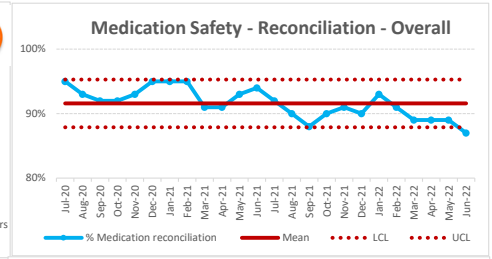
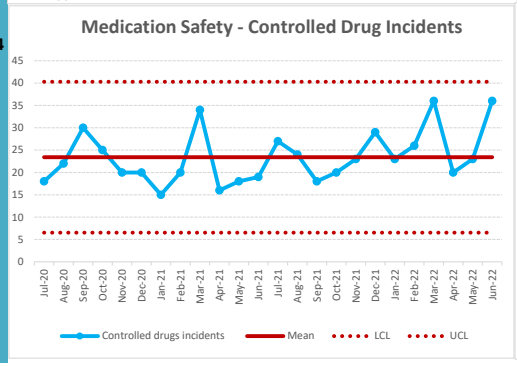
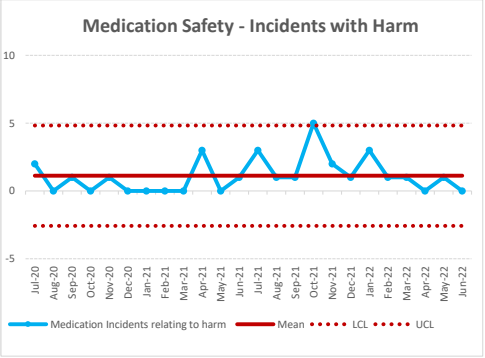
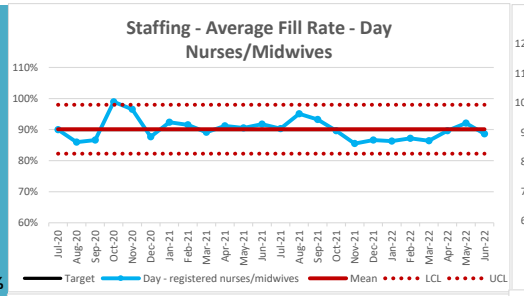
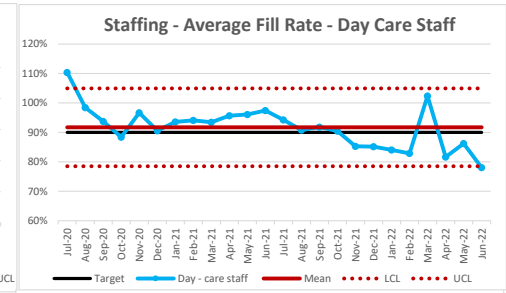
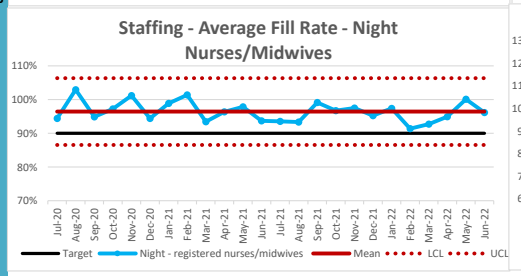
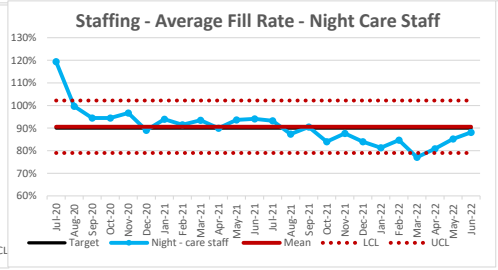
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
8. Inpatient Falls & harm levels Target: 20% or more decrease from 21/22 (590 Inpatient Falls in 2021/22)	Inpatient Falls; All Falls; Falls - All Harm; Falls Per 1000 Bed Days; Falls - Avoidable Harm	Assurance: N/A Annual Target. Variation: Common Cause (Normal) variation.	Variation in documentation is noted across inpatient wards in relation to falls risk assessments, falls care plans and bed rail risk assessments. Weekly Harm Free Care meetings have identified areas for improvement in relation to identifying risk for patients with no cognitive impairment.	Risk assessment documentation has been standardised within the electronic system with input from clinical staff. Falls walkarounds continue, including a Chief Nurse safety walkaround focussed on falls. Feedback reports are shared with relevant Ward Managers, Matrons, Lead Nurses and Associate Chief Nurses for Planned/Unplanned Care with suggested actions. The Patient Safety Improvement Nurses have started a programme of 'Bitesize' education sessions on IM&C, 3 sessions delivered in June. The sessions are scenario based, interactive and encourage challenge and discussion to ensure assessment of falls risks are fully identified. Falls prevention work on wards is driven by ward managers and overseen through the Senior Nursing Teams.
53 total falls were reported in June 2022. 43 of these were inpatient falls. There were 2 inpatient falls with harm reported in June 2022.				
9. Pressure Ulcers Target: 10% reduction based on 91 in 2021/22	Pressure Ulcers - Category 2; Pressure Ulcers - Category 3; Pressure Ulcers - Category 4; Community Acquired Pressure Ulcers	Assurance: N/A Annual Target. Variation: Common Cause (Normal) variation.	Variation in the identification of risk, associated with prolonged waits in the Emergency Department and the inconsistency in frequency of prescribed pressure prevention care on the wards, has contributed to the incidence of pressure ulcers in June 2022.	RCA meetings continue monthly chaired by the Deputy Chief Nurse and immediate learning is identified. Areas of increased incidence have identified care plans in place which are overseen by the Associate Chief Nurses. The Quality Improvement Team work closely to support ward staff to continue their improvement plans, such as visible displays of days since last pressure ulcer and turning prompts.
There were 7 hospital acquired category 2 pressure ulcers in June 2022.				

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
System Oversight Framework (SOF)
Care Quality Commission (CQC)
Risk Register (RR116)
Trust Strategy (S)

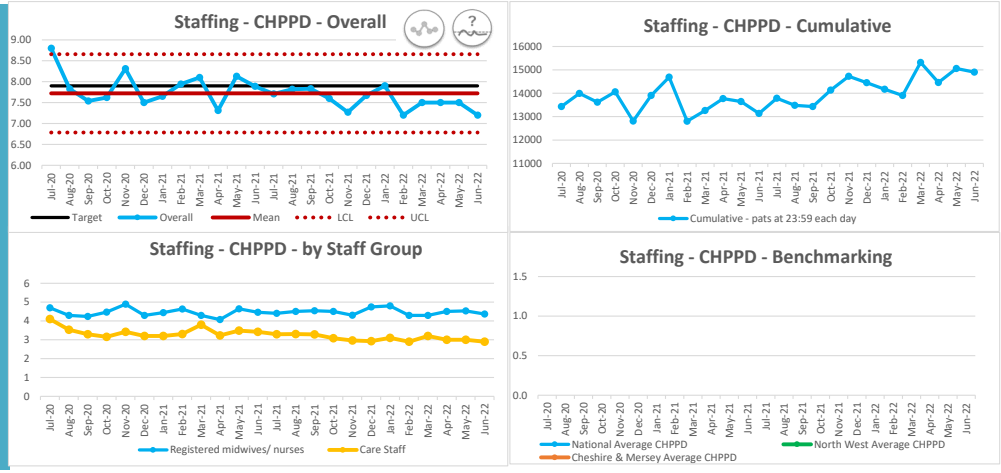
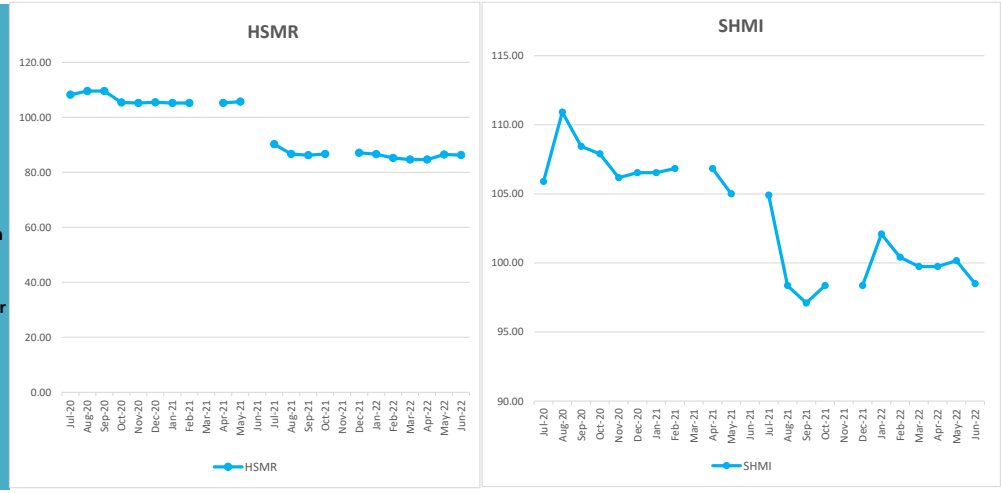
Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
10. Medication Safety Reconciliation within 24 hours Target: 80%	The Trust achieved 57.00% for medicines reconciliation within 24 hours and 87.00% for overall medicines reconciliation.	   	Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	% medicines reconciliation achieved within 24 hours continues to be adversely impacted by the need for a focus on managing system pressures / discharges and two bank holidays in month. Staff absences within the team have also had an impact. Overall number of medicines reconciliation was supported by filling rota gaps through use of staff overtime/additional hours. Compliance is expected to improve when new staff commence in post, 2 pharmacists joined the Trust in June. Controlled drug incident reporting increased following the CD audits undertaken in month. The majority of controlled drug incidents are documentation, policy or administration related, action plans for improvement are developed with each area and shared.	With staff in post and use of real time data (new database), work will focus on undertaking MRs closer to the front door and raising overall % in Surgical Specialties & Women's & Children's. Review of patients who did not receive a medicines reconciliation is undertaken to assess/report risk/harm. Ongoing recruitment. Monthly self-assessment and quarterly CD audits continue, with support in place for areas highlighted for improvement. Medicines Improvement Group membership includes the Senior AHP Manager & Senior Nurse Manager, Planned Care for oversight of process in their areas of responsibility.
11. Staffing - Average Fill Rate Target: 90%	In June 2022, the average staffing fill rates were: Day (Nurses/Midwife) 89.00% Day (Care Staff) 78.00% Night (Nurses/Midwife) 96.00% Night (Care Staff) 88.00%	    RR115 RR1108	Assurance: N/A Grouped Indicator Variation: N/A Grouped Indicator	Additional beds in use across the Trust due to increased demand in the Emergency Department, gaps in staffing due to the resurgence of COVID-19, and increased acuity and a large number of super stranded patients, have contributed to the reduction in fill rates across 3 of the 4 measures.	Safe staffing is formally reviewed twice daily by the senior nursing team with touch points through the 24hr period. Acuity and activity are monitored to ensure safe patient care at all times and staff are moved to areas of greater need where necessary. All wards have senior nurse oversight by a matron and lead nurse. Recruitment continues on a rolling programme with close oversight from the Deputy Chief Nurse and Trust Nursing Workforce Lead. WHH continue to be part of the International Recruitment planning for Cheshire and Mersey.

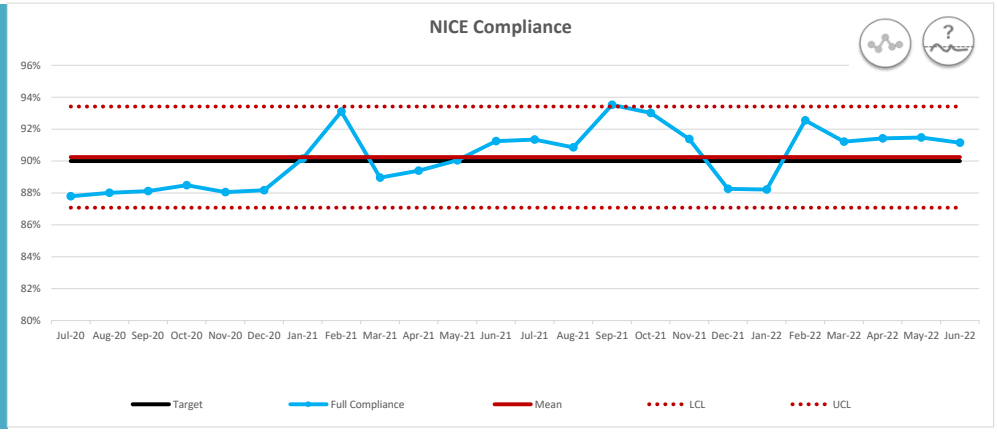
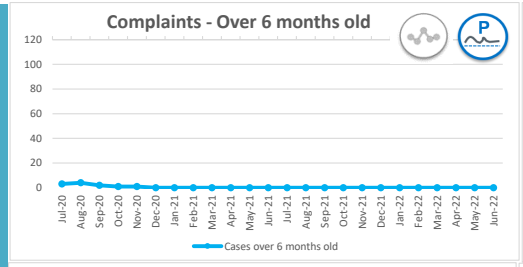
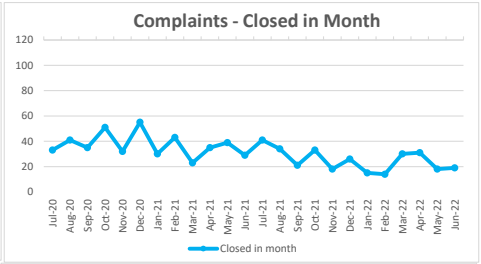
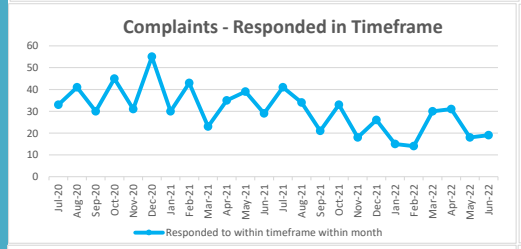
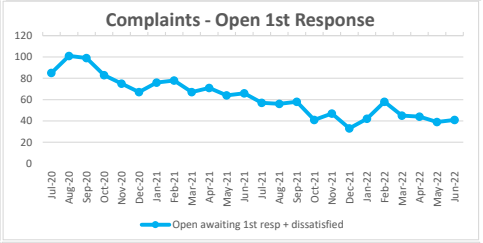
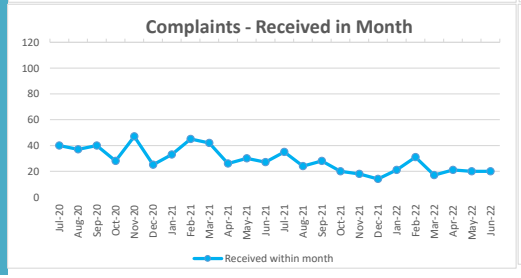
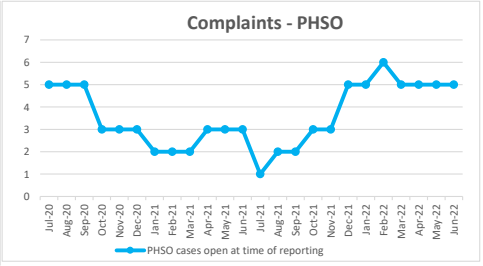
Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
12. Staffing - Care Hours Per Patient Day (CHPPD) Target: 7.9 CHPPD	In June 2022, the average CHPPD were: Nurse/Midwife: 4.4 hours Care Staff: 2.9 hours Overall: 7.2 hours		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	The CHPPD June data is slightly lower than noted for May which was 7.5 overall. Gaps in staffing, due to sickness absence and extra beds open across the Trust have contributed to the reduction.	Safe Staffing is formally reviewed twice daily by the senior nursing team with additional touch points throughout the 24hr period. Close working with NHS Professionals (NHSP) to ensure any staff required to fill gaps are requested in a timely manner, with colleagues from NHSP in attendance at staffing meetings. Recruitment continues on a rolling programme with close oversight from the Deputy Chief Nurse and Trust Nursing Workforce Lead. WHH continue to be part of the Cheshire and Mersey Heath Care Support Workers Recruitment Programme. The opening of additional beds across the Trust impacts on CHPPD and the use of temporary staffing supports safety in those areas.
13. Mortality ratio - HSMR Target: Plan 14. Mortality ratio - SHMI Target: Plan	SHMI and HSMR are within the expected range. The Hospital Standard Mortality Ratio (HSMR) in month was 86.28. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 98.50.		N/A - No SPC/Target	No variation. HSMR and SHMI remain within expected range. NB: The gaps in the charts relate to the time periods whereby our external provider (HED) did not produce a report with the HSMR/SHMI.	Mortality reviews continue to be undertaken alongside the governance incident process to ensure triangulation and learning. SHMI and HSMR continues to reduce month on month.

Quality Improvement - Trust Position

Appendix 2

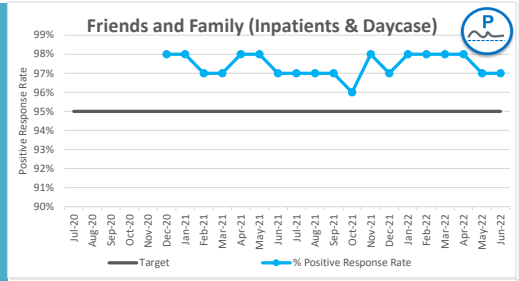
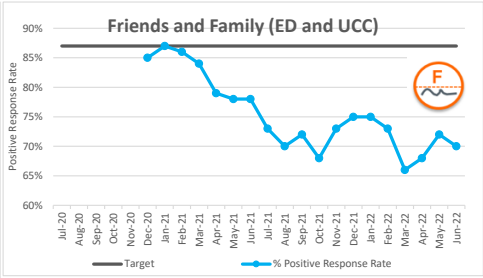
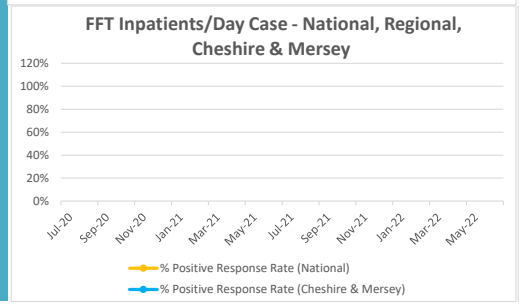
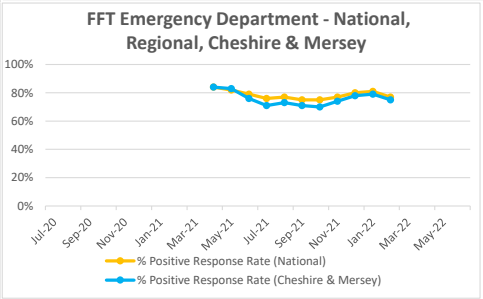
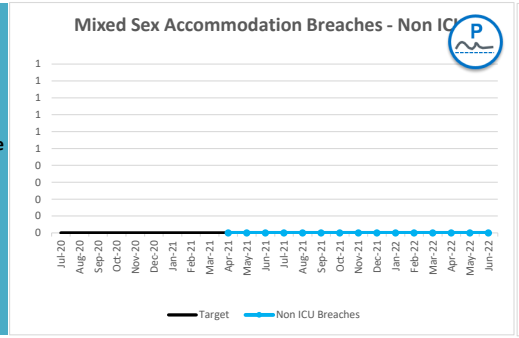
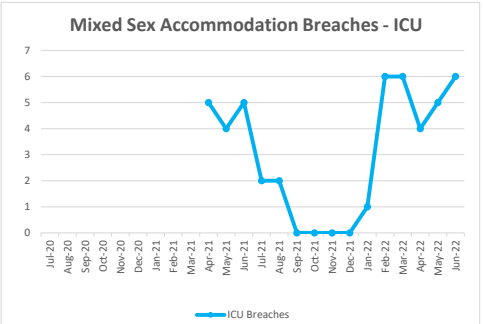
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
15. NICE Compliance Target: 90%	The Trust achieved 91.15% in month.		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	The Trust has met the target of achieving over 90.00% compliance.	The Clinical Effectiveness Manager is working closely with leads to ensure the completion of outstanding guidance. A review of partial compliance is being undertaken. Monitoring continues through CBU Governance Meetings.
16. Complaints Target: Zero complaints open over 6 months old/in the backlog.	In June 20 new complaints were received to the Trust which was an increase of 1 from the previous month. There have been 1 dissatisfied received in month, which is a positive decrease of 2.	     	Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	The Trust continues its performance in the timeliness of responding to complaints. There continue to be no complaints over 6 months old, and all complaints are currently within date. The PHSO position has remained static with no new cases since February 2022.	All complaints continue to be monitored to ensure a timely response is completed and directed to PALS when appropriate.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
System Oversight Framework (SOF)
Care Quality Commission (CQC)
Risk Register (RR116)
Trust Strategy (S)

Quality Improvement - Trust Position

Appendix 2

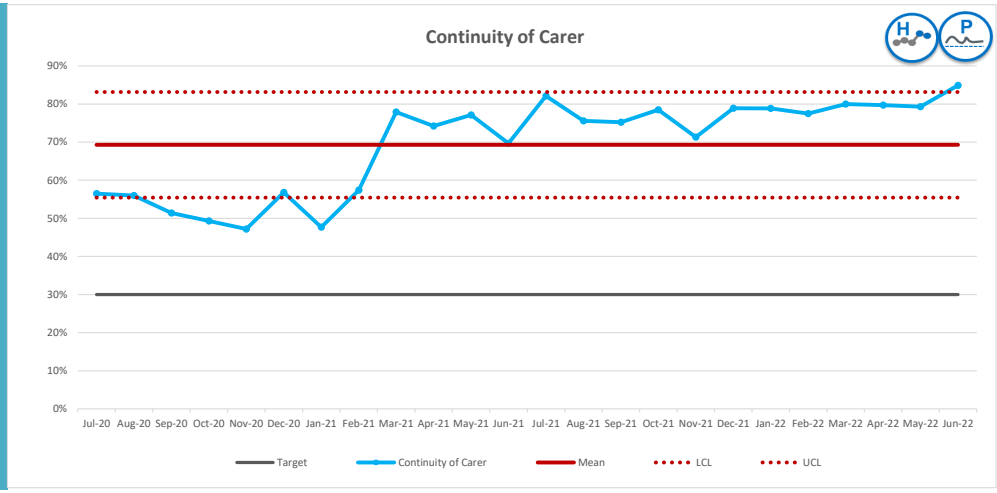
	Trust Performance	Trend		Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
17. Friends and Family (Inpatients & Day cases) **Target: 95%** **18. Friends and Family (ED and UCC)** **Target: 87%**	**The Trust achieved 97.00% in month for Inpatient & Day case FFT and 70.00% for ED/UCC FFT.**			**(IP/DC) Assurance: The Trust consistently passes the target.** **(IP/DC) Variation: N/A - Not enough datapoints.** **(ED/UCC) Assurance: The Trust consistently fails the target.** **(ED/UCC) Variation: N/A - Not enough datapoints**	**ED/UCC - The Trust achieved 70.00% positive feedback in Friends and Family Test results in June 2022 which is a 2.00% decrease from a rating of 72.00% in May 2022.** **Inpatient/Day Case - The Trust achieved 97.00% positive recommendation rate in June 2022.**	**ED/UCC - A CQC mock inspection was undertaken in March 2022 with subsequent actions to address patient experience - this is monitored through Patient Experience Sub-Committee and Moving to Outstanding Group. In May/June 2022 the reintroduction of patient visiting in ED and other Urgent and Emergency Care pathways commenced in line with national guidance.** **Inpatient/Day Case – Patient Experience Sub-Committee continues to monitor feedback and subsequent themes on a monthly basis. The Trust continues to be highly recommended through the FFT responses for inpatients and outpatients.**
						
19. Mixed Sex Accommodation Breaches (Non ITU Only) **Target: Zero**	**There were 0 mixed sex accommodation incidents outside of the ITU during June 2022. There were 6 MSA incidents within the ITU.**			**Assurance: The Trust consistently passes the target.** **Variation: N/A - not enough datapoints.**	**There were 6 mixed sex accommodation breach reported in June 2022 in the Intensive Care Unit. There were zero breaches within any other ward area.**	**The prevention of mixed sex breaches within the ITU department is a focus for the Patient Flow Team and the Silver Manager in hours and the Senior Manager on call out of hours. The request to move patients out of the ITU department is considered at every bed meeting and is balanced against the demand for beds elsewhere across the Trust. Improvement work has started in the Unplanned Care Group with specific objectives related to right patient, right place, right time, with the reduction of mixed sex breaches as a priority.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
System Oversight Framework
Care Quality Commission
Risk Register
Trust Strategy

Quality Improvement - Trust Position

Appendix 2

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
20. Continuity of Carer **Target: 51%** **In June 2022, 100% of Warrington & Halton women are booked onto a MCoC pathway, if 'out of area' bookings are included the figure is 84.9% as we cannot provide the postnatal aspect of the pathway. 100% of in area and 99.6% of all BME women were booked onto a MCoC pathway.**		**Assurance: The Trust consistently passes the target.** **Variation: Special Cause Variation of a improving nature.**	**The Trust achieved 84.90% onto a CoC pathway (including intrapartum care) in June 2022. This figure varies month on month as it is impacted by the number of women who are "out of area" being booked for care at WHH.**	**WHH continues to work towards ensuring women booked on a pathway receive continuity across the pathway. Updated national guidance was published in October 2021 in relation to Continuity of Carer and a revised action plan is being prepared to reflect the new recommendations.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

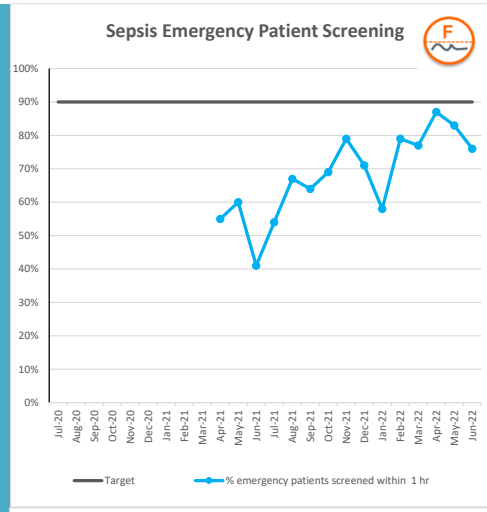
Key:

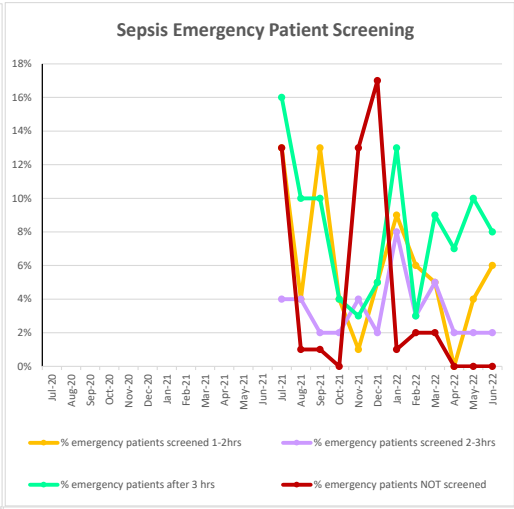
System Oversight Framework | Risk Register | Care Quality Commission | Trust Strategy

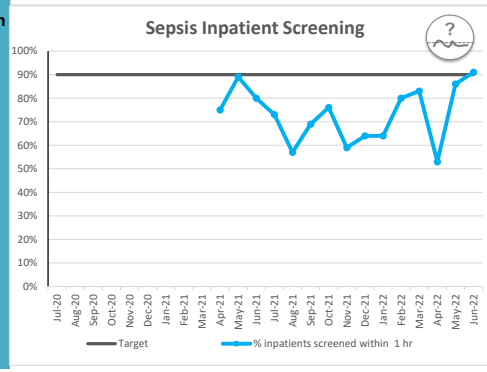
Quality Improvement - Trust Position

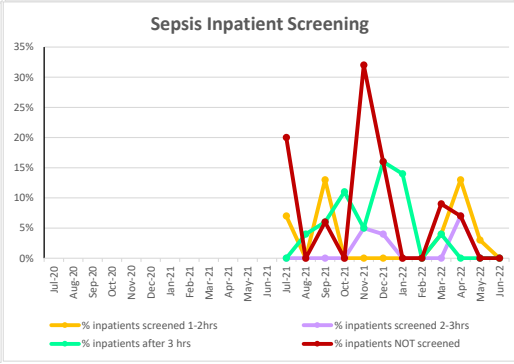
Appendix 2

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
21. Sepsis - % screening for all emergency patients. Target: 90% 22. Sepsis - % screening for all inpatients Target: 90%	The Trust achieved: • 76.00% Sepsis screening for all emergency patients with suspected sepsis within 1 hour. • 91.00% screening for all inpatients with suspected sepsis within 1 hour.	(Emergency) Assurance: The Trust consistently fails the target. Variation: N/A - Not enough datapoints (Inpatient) Assurance: The Trust inconsistently passes/fails the target. Variation: N/A - Not enough datapoints.	The increased number of patients at any one time within the Emergency Department, coupled with gaps in staffing through sickness absence has contributed to the reduction in screening emergency patients within 1 hour of suspected sepsis diagnosis.	Sepsis Improvement Groups continue for both the Emergency Department and inpatients. The Patient Safety Improvement Nurses visit the wards and deliver training, check all patient NEWS score daily and work with the Quality Improvement Team on wards A6/7/8 currently as part of a Trust wide improvement plan for inpatient sepsis management. The requirement for staff to complete blood culture training has been highlighted as a theme across the wards. Work is underway to facilitate training of all band 6 nurses on inpatient wards, as per Trust IPC policy, by December 2022. A training trajectory is being developed and extra training sessions are in place. All appropriate staff in the Emergency Department are trained.



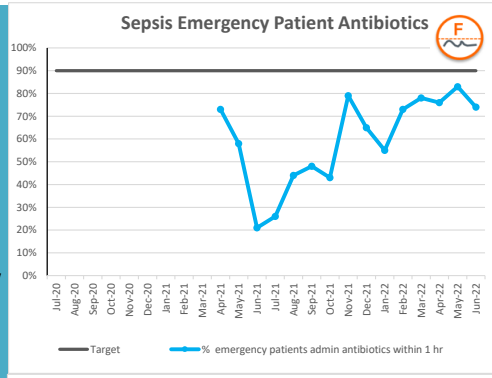
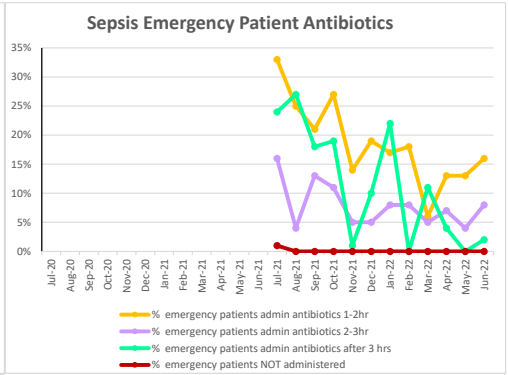
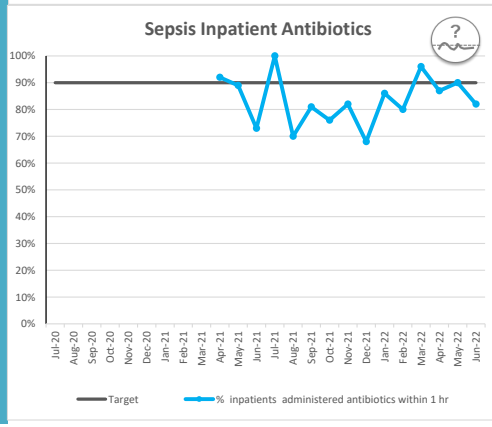
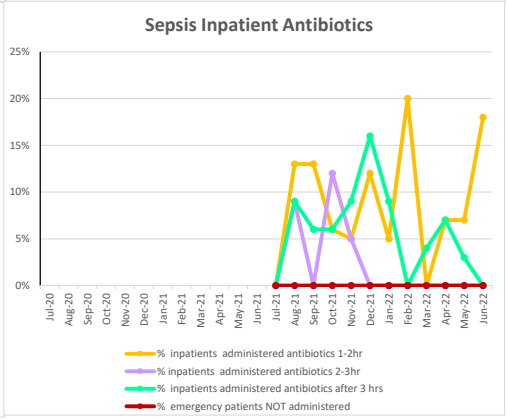






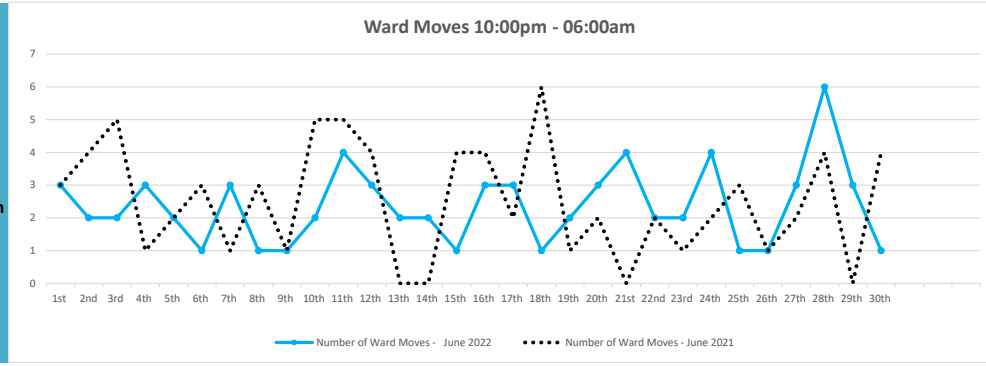
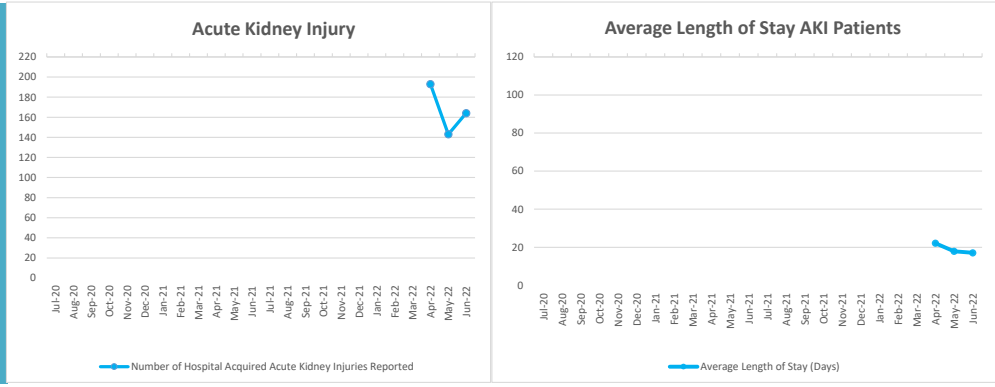
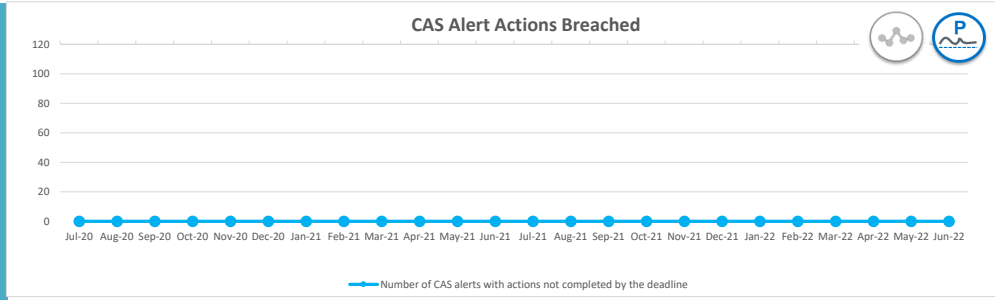
Quality Improvement - Trust Position

Appendix 2

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
23. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag **Target: 90%** **24. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis** **Target: 90%** **The Trust achieved:** **• 74.00% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made.** **• 82.00% of inpatients had antibiotics administered within 1 hour of a diagnosis of sepsis being made.**	   	**(Emergency)** **Assurance: The Trust consistently fails the target.** **Variation: N/A - Not enough datapoints** **(Inpatient)** **Assurance: The Trust inconsistently passes/fails the target.** **Variation: N/A - Not enough datapoints.**	**The increased number of patients at any one time within the Emergency Department, coupled with gaps in staffing through sickness absence has contributed to the reduction in patients receiving antibiotics within 1 hour of suspected sepsis diagnosis. In addition inconsistencies have been noted with the prescription of 'Stat' dose, which can lead to a delay in administration.**	**The Quality Improvement Team have started process mapping on one of the inpatient wards to support a reduction in time taken to administer antibiotics as this is cited as a contributory factor in the delay of administration. Sepsis training availability is reinforced every day at Trust Wide Safety Brief, and via the Operational Patient Safety Group, with good uptake, currently at 75.00% compliance with plans for areas to improve. In addition, the recently launched AIMS course includes sepsis training and is available for staff to complete every 3 years. 804 staff in the Trust are eligible and 68 have completed training since May 2022. The Patient Safety Improvement Nurses have started 'scenario based teaching' on the patient wards to help reiterate to the staff the importance of completing the 'Sepsis 6' and the rationale behind it, this is further supported by the clinical leaders in the areas.**

Quality Improvement - Trust Position

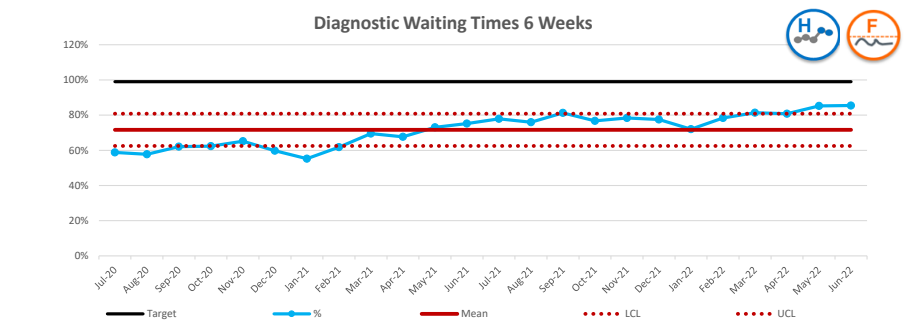
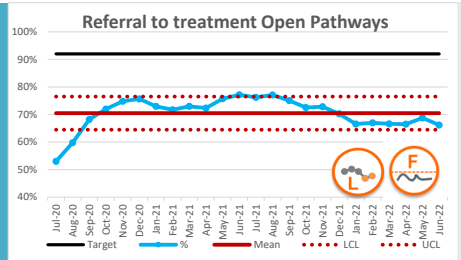
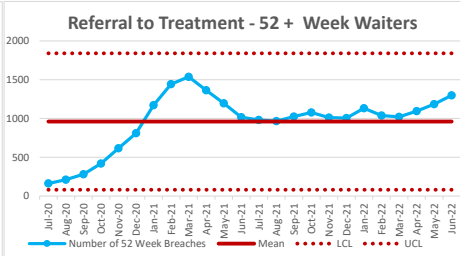
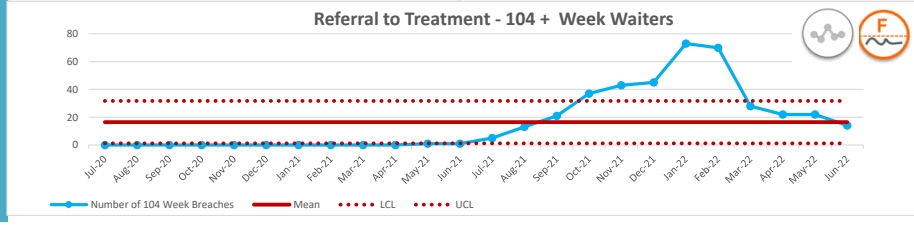
Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
25. Ward Moves between 10:00pm and 06:00am No Target	There was a total of 71 ward moves between 10pm-6am in June 2022 compared to 75 in June 2021.		N/A - Monthly/Annual Comparison.	The reason for the reduction in ward moves after 10pm for this reporting period compared to last year is as a result of the out of hours patient flow and senior manager on call minimising non essential clinical patient moves.	Increased focus on the reduction of non-essential clinical patient moves at night is part of the improvement workstreams in relation to patient flow. In addition, automatic notifications are applied for patients who have a learning disability or mental health need. This notification is monitored by senior nurses who undertake a welfare check to ensure no inappropriate moves take place. This process has helped to improve the positive reduction in out of hours patient moves.
26. Acute Kidney Injury Target: Less than previous month	There were 164 acute kidney injuries reported in month.		N/A - Not enough datapoints.	The increased length of Stay (LOS) across the Trust has been identified as a contributory factor to the development of AKI, and whilst there has been an improvement overall in hospital acquired AKI incidence, further work is required.	At present WHH are improving from a mortality perspective at 24.00% from 31.00% with more improvements anticipated with the initiation of the clinic and AKI role in the Acute Care Team. Short term the Trust will commence AKI Hot Clinics and the new AKI role within the Acute Care Team by the first week in August 2022. Teaching for the prevention of AKI is available on the Trust AIMS training.
27. CAS Alerts - Target: All relevant CAS Alerts actioned within timescales	There were 0 CAS alerts with breached actions in month.		Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) Variation.	There is no variance from the previous month as no alerts have been breached.	CAS alerts are monitored via the Trusts Health Safety Sub-Committee and Medical Devices Group. Action plans and monitoring arrangements are reviewed weekly by the Health & Safety Department.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

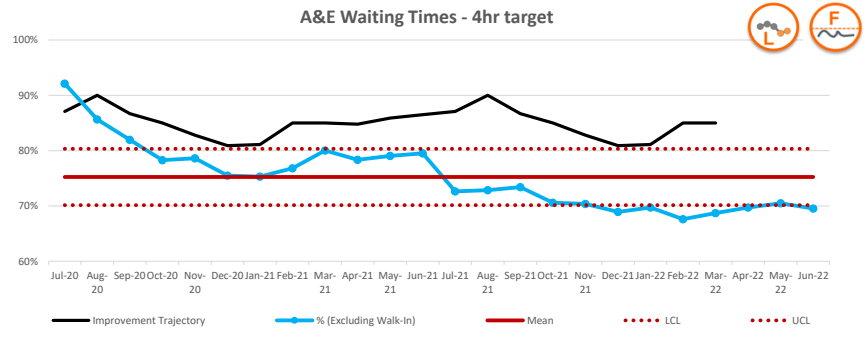
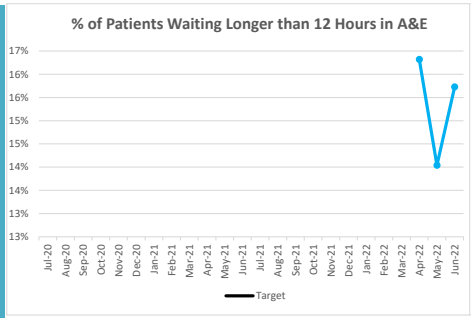
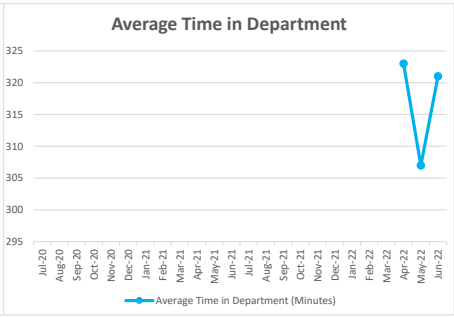
Key: Risk Register RR116 | System Oversight Framework SOF | Care Quality Commission CQC

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
28. Diagnostic Waiting Times 6 Weeks **Target: 99%** SOF CQC **The Trust achieved 85.47% in month.** RR1215 RR1125		**Assurance: The Trust consistently fails the target.** **Variation: There is special cause variation of a improving nature**	**The diagnostic standard was not achieved in June 2022. The position continues to be managed in line with the recovery trajectory.**	**A recovery plan has been agreed and patients are being clinically prioritised accordingly in line with national guidance. This links to the recovery plan for elective surgery and is monitored weekly at the Performance Review Group (PRG). Although there has been good progress in radiological modalities, challenges remain in Endoscopy, Cardiorespiratory, Cystoscopy and CT.**
29. Referral to treatment Open Pathways **Target: 92%** SOF CQC **The Trust achieved 64.47% in month. There were 1298, 52 week breaches and 14, 104 week breaches in June 2022.** **30. RTT - Number of patients waiting 104+ weeks Target: ZERO** RR1125 RR1215	  	**Assurance: The Trust consistently fails the target.** **Variation: There is special cause variation of a concerning nature.** **Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) Variation.**	**RTT performance, 52 and 104 week wait performance in June was in line with the Trust's 2022/23 plan.**	**Recovery of the elective programme is taking place with:** **• Elective activity being prioritised along with all patients being clinically reviewed in conjunction with guidance released for the management of patients.** **• Elective capacity has been restored at the Halton Elective Centre and the Captain Sir Tom Moore Centre.** **• Restoration and recovery plans for 2022/23 have been drawn up in line with Operational Planning Guidance.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key: Risk Register RR116 | System Oversight Framework SOF | Care Quality Commission CQC

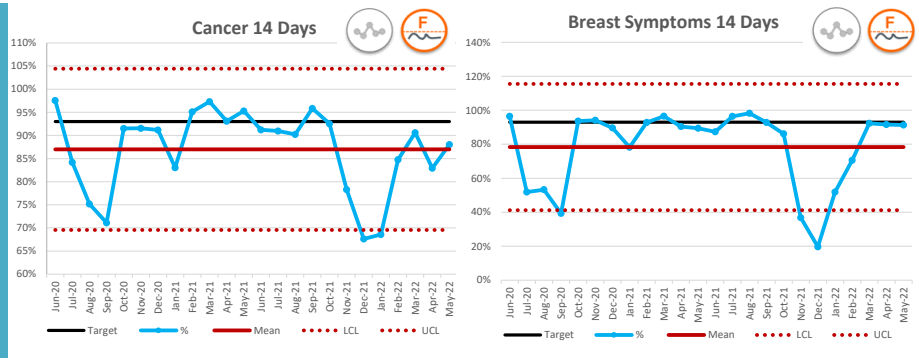
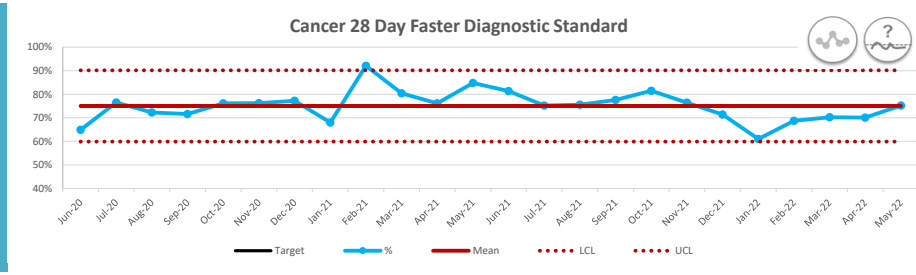
Access & Performance - Trust Position

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
31.A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. **Target: 95%** **32. Four Hour Standard Waiting Times - ICS Trajectory** **Target: Trajectory** RR224 **The Trust achieved 69.53% excluding Widnes walk ins in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of a concerning nature**	**Performance continues to be negatively impacted by high attends, long length of stay as a result of community discharge delays and the impact of COVID-19 Waves.**	• **System partners have been engaged to support the reduction of Super Stranded Patients in the bed base to create capacity in order to support flow.** • **System resource investment in order to support Pathway 1 discharges.** • **Additional beds remain open on the Halton site to support bed capacity and flow.** • **Same Day Emergency Care Centre opens July 2022.**
33. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge. **Target: 2% or less** **34. Average time in department ED** **No Target** **There was 15.73% of patients in A&E were waiting longer than 12 hours from presentation to admission/discharge. There average time in department was 321 minutes.**	 	**N/A - Not enough datapoints.**	**12 hour performance continues to be monitored. This is also in line with the trend seen regionally and nationally. The Trust continues to perform well when compared to other Trusts against this standard. The key themes for the breaches are the continuing high urgent care attends and high occupancy restricting flow through ED.**	**The Trust will continue to monitor and manage compliance around the 12 hour standard.**

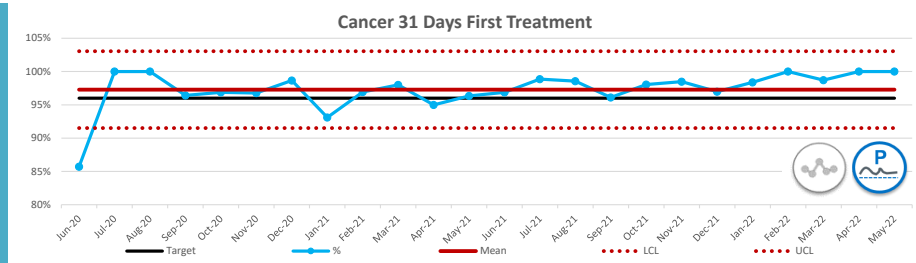
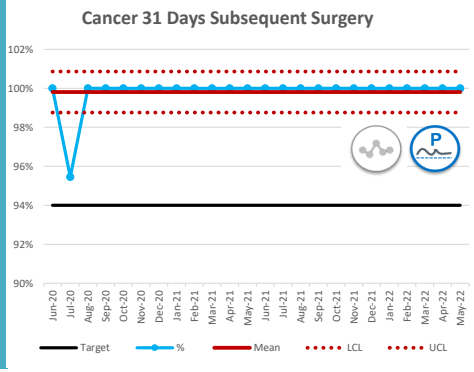
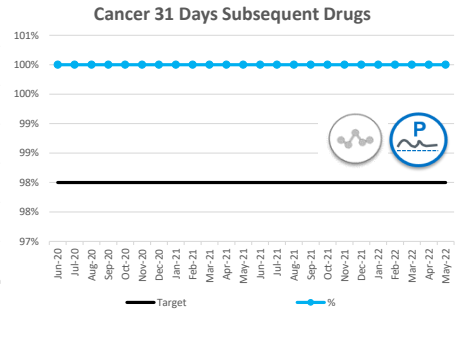
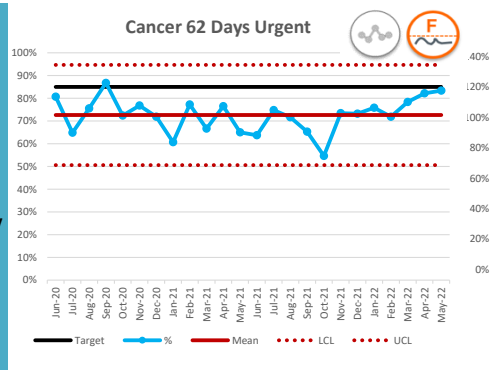
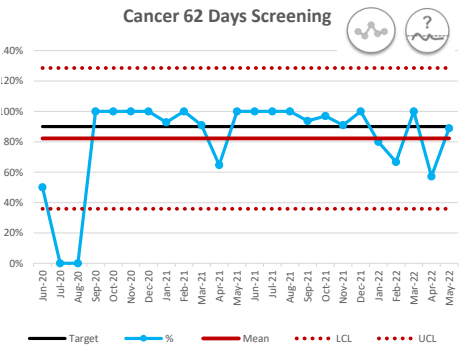
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key: Risk Register RR116 | System Oversight Framework SOF | Care Quality Commission CQC

Access & Performance - Trust Position

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
35. Cancer 14 Days Target: 93% 36. Breast Symptoms 14 Days Target: 93%	SOF CQC The Trust achieved 88.04% in May 2022 for Cancer 14 days and 91.30% in May 2022 for Breast Symptomatic. RR1125	 	(C14) Assurance: The Trust consistently fails the target. Variation: Common Cause (normal) variation. (Breast) Assurance: The Trust consistently fails the target. Variation: Common Cause (normal) variation.	Overall the 2 Week Wait narrowly missed the target in May with the continued impact of Wave 6 over this period. The previously reported deterioration in performance for Breast Symptomatic has fully recovered.	The Trust will continue to review capacity with clinical service restoration plans to support ongoing compliance against this standard. Performance against this standard is monitored via the Performance Review Group (PRG), the KPI sub-committee and the Clinical Services Recovery Oversight Group (CSOG). Targeted capacity and demand work has been initiated for the Breast service.
37. 28 Day Faster Cancer Diagnosis Standard Target: 75%	SOF The Trust achieved 75.24% in May 2022		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (normal) variation.	This indicator is still being impacted by waves of COVID-19.	The Trust will continue to monitor and review performance of this standard via the Performance Review Group (PRG) and the KPI Sub-Committee.

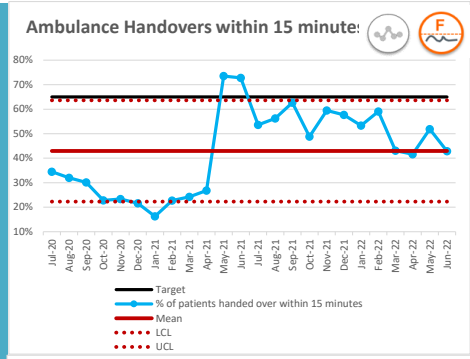
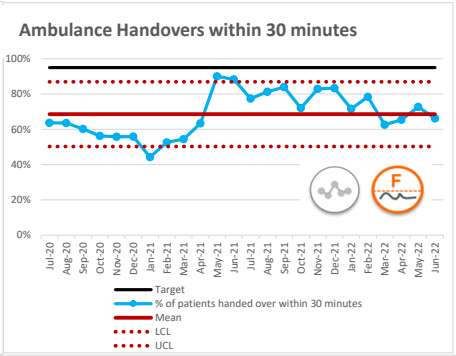
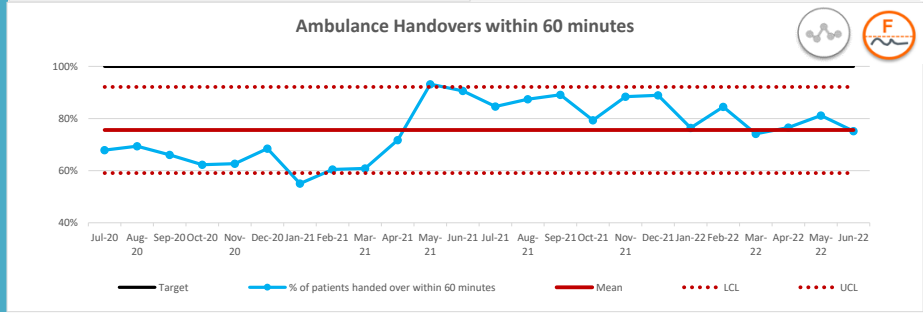
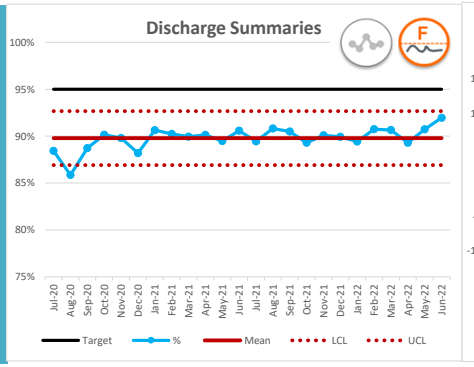
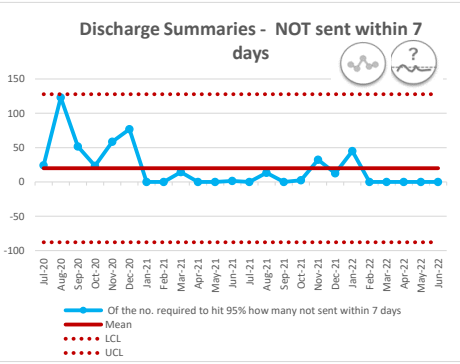
Access & Performance - Trust Position

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
38. Cancer 31 Days First Treatment Target: 96% 39. Cancer 31 Days Subsequent Surgery Target: 94% 40. Cancer 31 Days Subsequent Drug Target: 98% SOF CQC RR1125 The Trust achieved 100% for Cancer 31 days first treatment, 100% for surgery and 100% for drug treatment in May 2022.	  	(Surgery) Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation. (Drugs) Assurance: The Trust consistently passes the target. Variation: Common Cause (Normal) variation.	The 31 day cancer target was achieved in May 2022. Good compliance against this standard continues to be tracked.	There remains a risk for performance due to the impact of the pandemic. Capacity is being reviewed in line with clinical service restoration plans.
41. Cancer 62 Days Urgent Target: 85% 42. Cancer 62 Days Screening Target: 90% SOF CQC RR1125 The Trust achieved 83.33% for Cancer 62 Day Urgent and 88.89% for Cancer 62 Day Screening in May 2022.	 	(Urgent) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation. (Screening) Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	The 62 day urgent target was not achieved in June 2022 despite an improving position. The Trust is meeting the Cheshire & Merseyside Cancer Alliance agreed trajectories for improvement.	There remains a risk for performance due to the impact of the pandemic.

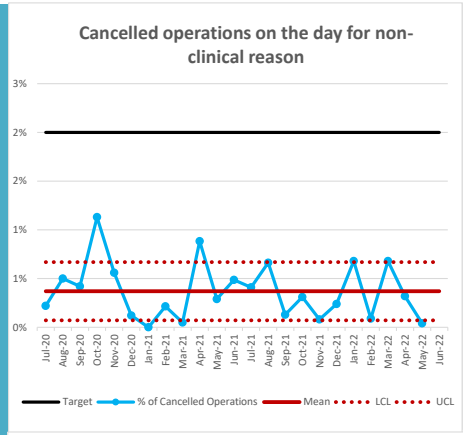
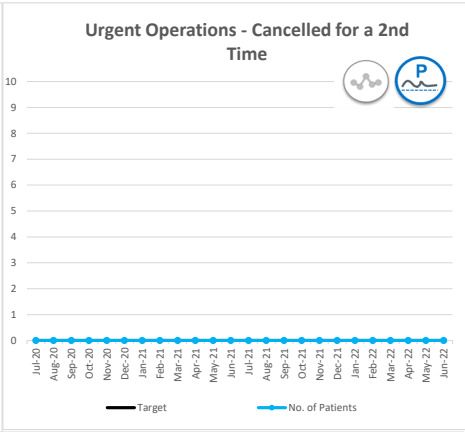
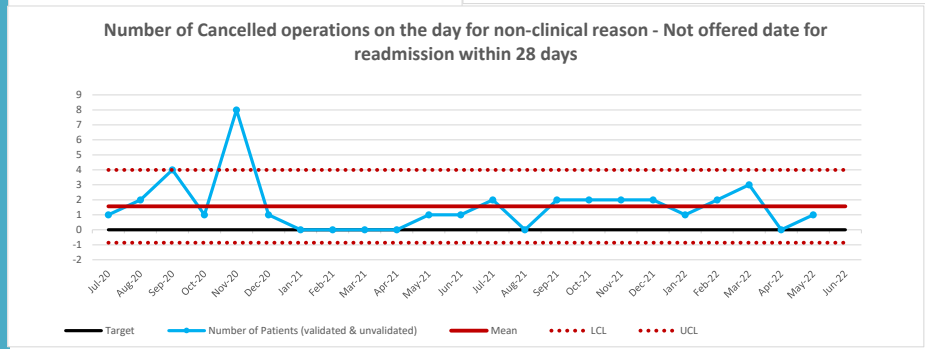
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

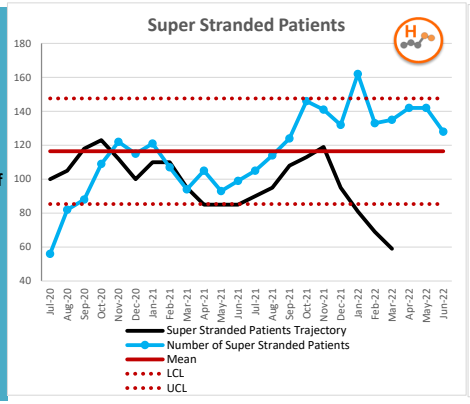
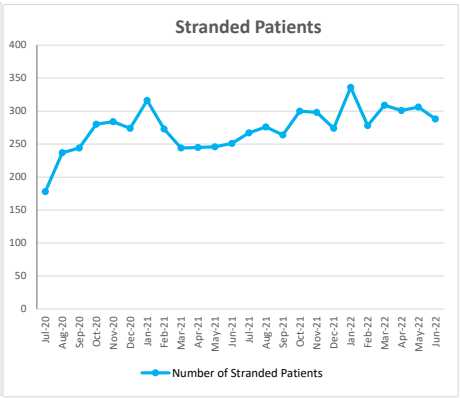
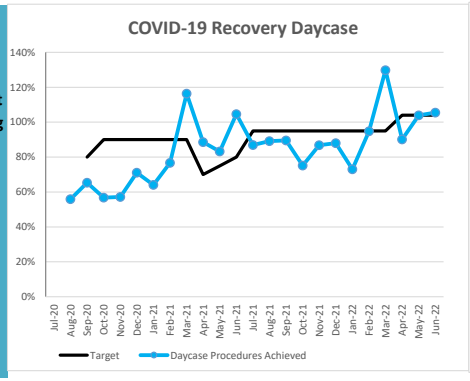
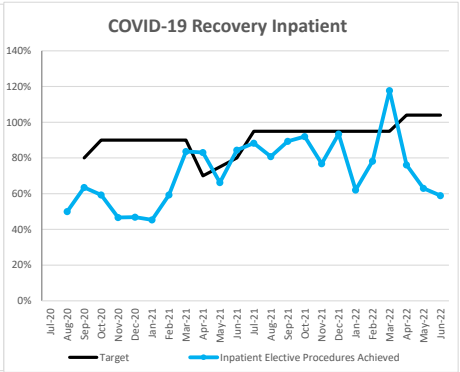
Key: Risk Register (RR116) | System Oversight Framework (SOF) | Care Quality Commission (CQC)

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
43. Ambulance Handovers within 15 minutes **Target: 65%** **44. Ambulance Handovers within 30 minutes** **Target: 95%** **45. Ambulance Handovers within 60 minutes** **Target: 100%** **In month 42.89% of patients were handed over within 15 minutes, 66.19% were handed over within 30 minutes and 75.21% were handed over within 60 minutes.** SOF	  	**(15)** **Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.** **(30) Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.** **(60)** **Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**Handover performance has improved following the improvement collaborative with the North West Ambulance Service (NWAS).**	**In May 2021, the Trust began a service improvement collaborative with NWAS to improve ambulance handover waiting times. The Trust will continue to work in partnership with the NWAS to identify and implement improvements.**
46. Discharge Summaries - % sent within 24hrs **Target: 95%** **47. Discharge Summaries - Number NOT sent within 7 days** **Target: ZERO** **The Trust achieved 88.35% in month. There was 1 discharge summary not sent within 7 days required to meet the 95.00% threshold.**	 	**(24 hrs)** **Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.** **(7 Days)** **Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**Performance of discharge summaries within 24 hours has been maintained despite Wave 6 challenges. The reporting logic for this metric has now been agreed.**	**The Performance Review Group (PRG) continues to monitor this standard to support improvements.**

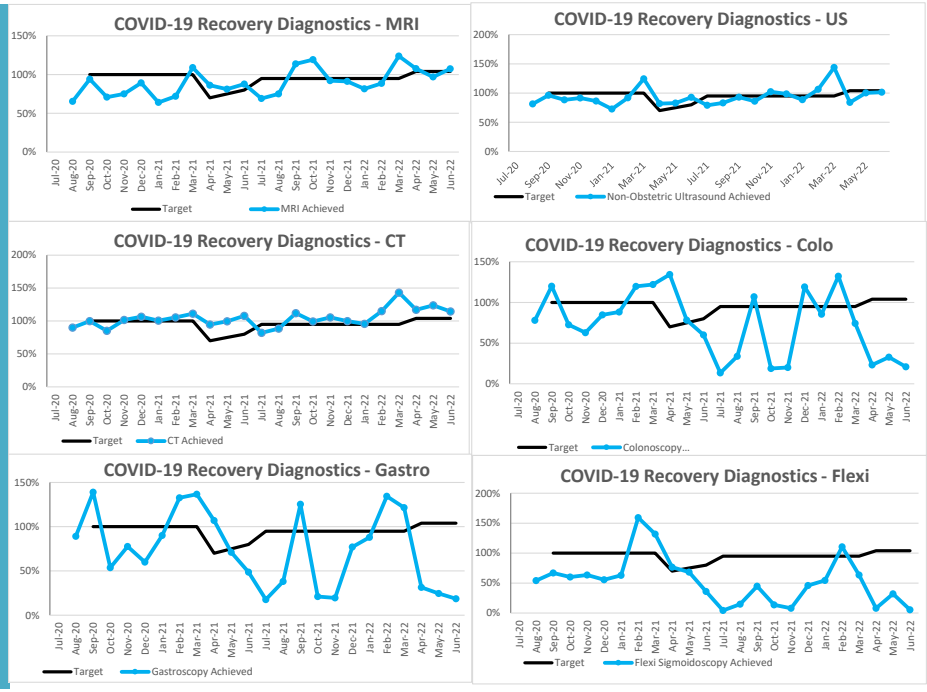
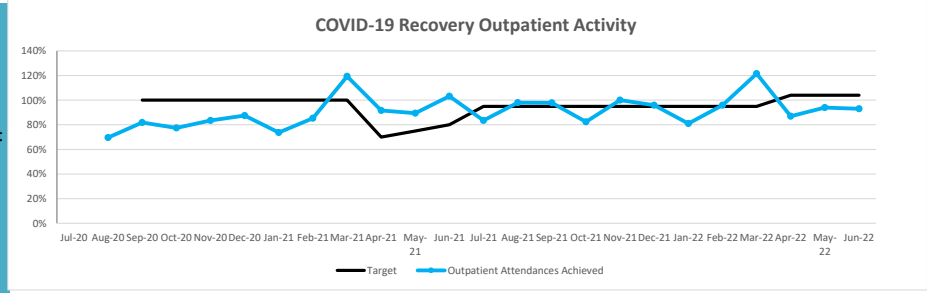
Access & Performance - Trust Position

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
48. Cancelled Operations on the day for a non-clinical reason **Target: Less than 2%** **49. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation** **Target: ZERO** **50. Urgent Operations - Cancelled for a 2nd Time** **Target: ZERO** CQC **Cancelled operations data validation for June is in progress.**	  	**(Urgent Ops) Assurance: The Trust consistently passes the target. Variation: Common Cause (normal) variation.**	**Compliance against this standard remains below the monitored threshold of 2.00% (positive).**	**Recovery of elective activity continues to be monitored via the Clinical Services Recovery Oversight Group (CSOG).**

Access & Performance - Trust Position

Trust Performance	Trend		Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
51. Super Stranded Patients **Target: Trajectory** There were 288 stranded and 128 super stranded patients at the end of June 2022. A Superstranded Patient Trajectory has not yet been agreed for 2022/23.			**Assurance: N/A Trajectory Not Agreed** **Variation: There is special cause variation of a concerning nature.**	**The number of Super Stranded patients continues to remain higher than trajectory as a result of the impact of COVID-19 and community and Local Authority discharge delays.**	**The Trust is working in collaboration with partners from local authorities and community providers to ensure community capacity is available throughout the pandemic.**
52. COVID-19 Recovery Elective Activity **Target: 104%** **% activity is against activity in the same month in 2019/20**	SOF **In June 2022, the Trust achieved the following % of activity against June 2019. This included 105.50% of Daycase Procedures and 58.98% of Inpatient Elective Procedures.** RR1125			**N/A - Grouped indicator.**	**Activity for June was slightly below the Trajectory due to the continued impact of Wave 6.**	**The Trust monitors progress weekly via PRG and Clinical Services Oversight Group (CSOG)**

Access & Performance - Trust Position

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
53. COVID-19 Recovery Diagnostic Activity **Target: 104%** **% activity is against activity in the same month in 2019/20**		**N/A - Grouped indicator.**	**The Trust did meet the diagnostic activity recovery trajectories for June 2022 across a number of specialties due to COVID-19 sickness. Colonoscopy, Flexi Sig and Gastroscopy have started to show an improvement. Cardiorespiratory, particularly Echo and Ultrasound remain the most challenged areas although now improving.**	**The Trust continues to restore clinical services in line with the national operating guidance.**
54. COVID-19 Outpatient Activity **Target: 104%** **% activity is against activity in the same month in 2019/20**		**N/A - Grouped indicator.**	**The June trajectory for Outpatients was not achieving due to the impact of Wave 6 and COVID-19 sickness, resulting in Outpatient Activity being stood down.**	**The Trust continues to restore clinical services in line with the national operating guidance.**

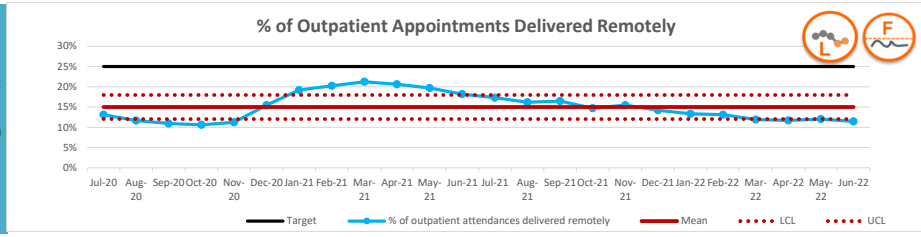
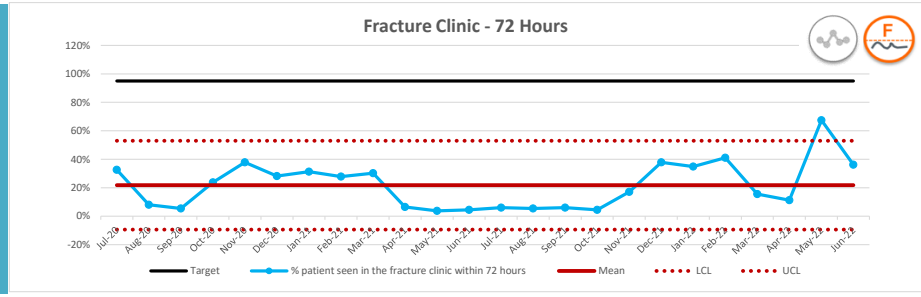
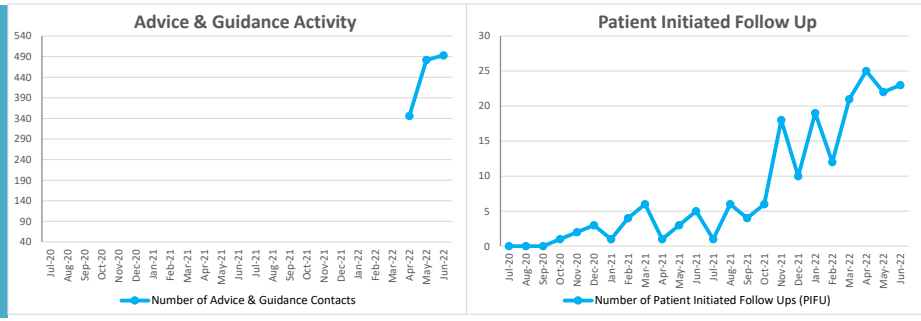
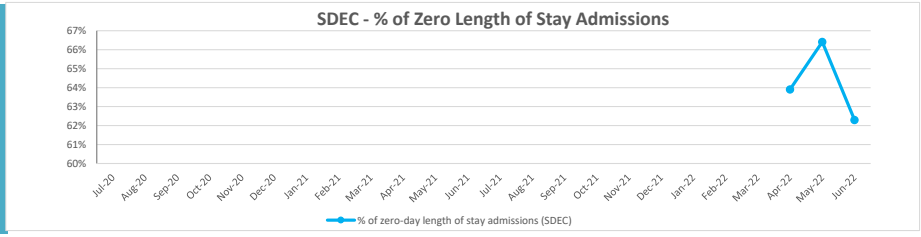
In June 2022, the Trust achieved the following % of activity against June 2019. This included:
107.47% of MRI
114.46% of CT
101.34% of Non-Obstetric Ultrasound
5.45% of Flexi Sigmoidoscopy
21.01% of Colonoscopy
18.60% of Gastroscopy

In June 2022, the Trust achieved 92.96% of Outpatient activity against June 2019.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

Key: Risk Register RR116 | System Oversight Framework | Care Quality Commission SOF CQC

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
55. Outpatient Activity Delivered Remotely Target: 25%	11.44% of Outpatient Appointments were delivered remotely in month.		Assurance: The Trust consistently fails the target. Variation: There is special cause variation of a concerning nature.	The Trust did not achieve the standard in month for % of outpatient appointments delivered remotely.	The Trust continues to identify opportunities to deliver additional outpatient activity remotely.
56. Patients seen in the Fracture Clinic within 72 hours Target: 95%	36.20% of patients were seen in the Fracture Clinic within 72 hours in month.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	Performance against the 72 hour standard deteriorated slightly in June due to the pressures on Trauma but is expected to recover for July.	This improvement is being sustained by the introduction of the Virtual Fracture clinic (VFC) and will be further improved with the introduction of e-trauma software to support the VFC implementation in the coming weeks.
57. Advice & Guidance (A&G) Activity Levels No Target 58. Patient Initiated Follow Up (PIFU) Activity Levels No Target	The Trust completed 493 Advice & Guidance Contacts and 243 Patient Initiated Follow Ups in month.		N/A - Not enough datapoints.	The number PIFU and Advice & Guidance contacts continues to increase in line with the 2022-23 operational plan.	The Trust monitors progress weekly via PRG.
59. % of zero-day length of stay admissions (as a proportion of total) based of SDEC Emergency Admissions No Target	62.00% of SDEC Emergency Admissions had a zero day length of stay.		N/A - Not enough datapoints.		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

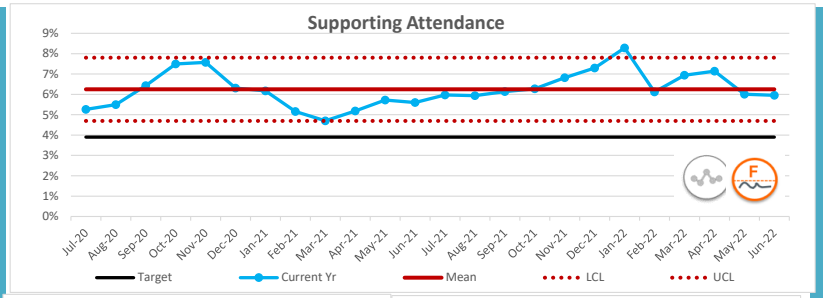
Key:
System Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

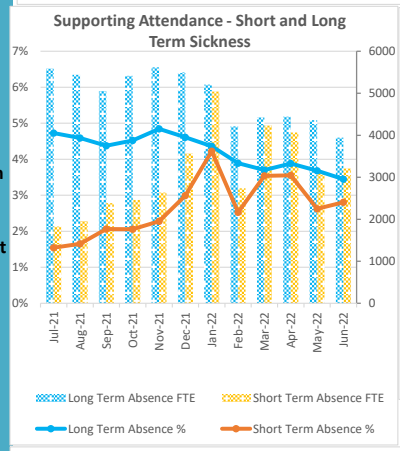
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

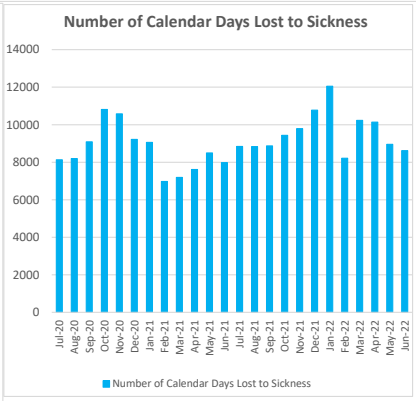
60. Supporting Attendance

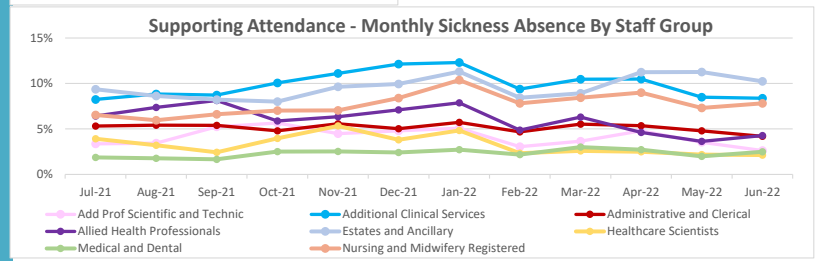
Target: Below 4.2%

The Trust's sickness absence rate was 6.25% in month. There were 8,615 calendar days lost to sickness in month.









Assurance: The Trust consistently fails the target.

Variation: There is common cause (normal) variation.

Sickness absence is 6.25% for June 2022, it was last reported as 7.44% in April 2022.

Short term absence is 2.80%, and long-term absence 3.45%.

Sickness absence in June 2021 was 5.90%.

Anxiety, Stress and Depression is the highest reason for sickness absence, followed by Chest and Respiratory problems.

The Trust implemented an updated Supporting Attendance Policy in February 2022 and transitioned existing employees under Attendance Management to the policy in April 2022, making the new framework fully operational. The policy launch was supported by a series of briefing sessions and communications across Care Groups, alongside one to one support for managers and staff under Attendance Management. Since the policy introduction, as reported for June 2022, sickness absence has reduced.

The Trust has introduced a series of management training sessions to equip leaders with the tools needed to effectively manage and support staff during periods of absence, with a focus on enabling attendance and supporting wellbeing.

There is a reset and refresh of the Supporting Attendance Steering Group. The group's work was previously focused on the development and implementation of the new Supporting Attendance Policy. A new group action plan will be developed with the aim to implement pro-active strategies to support attendance.

People Directorate Roadshow - provides a platform for line managers to ask questions and to receive the latest information. At the time of writing, one face to face and one virtual session have taken place, both well attended, and feedback has been positive.

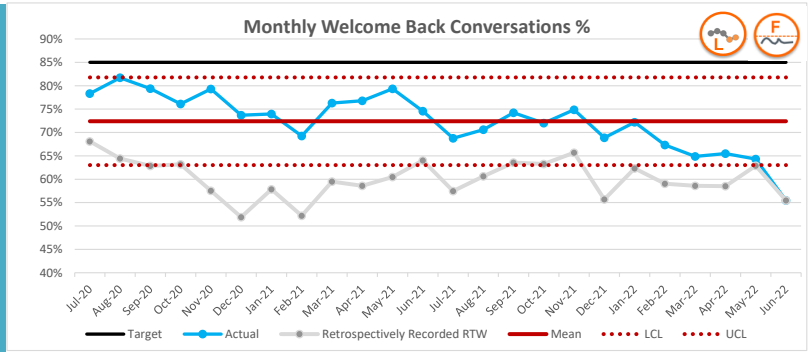
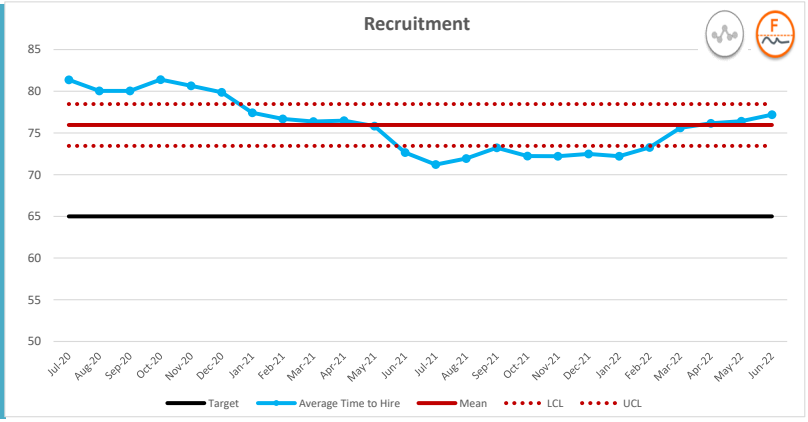
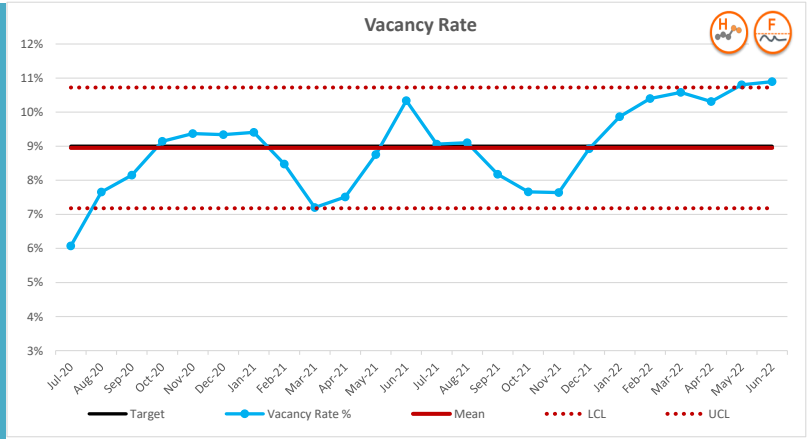
Occupational Health and Wellbeing continue to hold triangulation meetings with HR colleagues to review individuals who are under the formal stages of Supporting Attendance Management to progress the case, either through enhancing support, and/or developing interventions.

Benchmarking against the latest data available on Model Hospital in May 2022, we ranked 3rd lowest for providers in C&M region for sickness absence. Lower than St Helens & Knowsley, LUFT, Broadgreen, Wirral, East Cheshire and Southport & Ormskirk. This does not include our position in June 2022 which has seen a decrease in sickness absence from April 2022.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

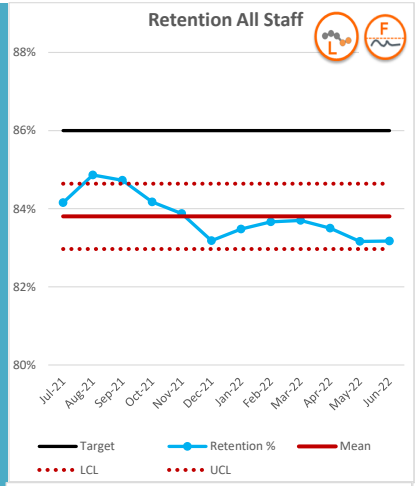
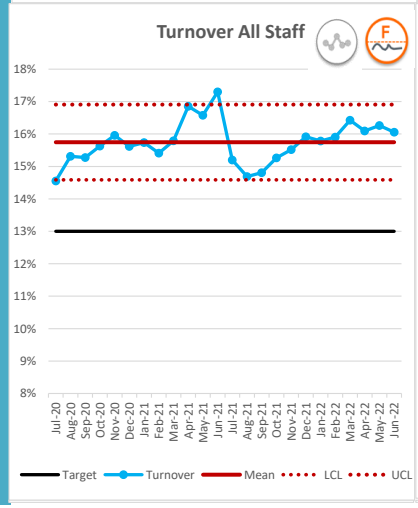
Key:
System Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
61. Welcome Back Conversations Target: 85%	Welcome Back Conversation compliance was 55.45% in June 2022.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	Welcome Back Conversations (WBC) compliance is 55.45% in June 2022. It is worth noting, previous months WBC compliance increases as managers input historic WBCs that occurred but were not recorded on the system at the time. The 12-month RTW compliance is 68.46%.	Specific targeted support by the HR Business Partnering Team continues within areas of high sickness and low compliance WBC figures. This includes training on WBC, and also inputting WBC dates. Bespoke training and one to one management coaching on Welcome Back Conversations are available and continue to be offered across all CBUs. In addition, there is full training available for line managers on the change of approach from 'Return to Work' to 'Welcome Back Conversations', which includes hints and tips on how to have those conversations focused on wellbeing and support for the individual.
62. Recruitment Target: 65 days or below	The average number of working days to recruit is 77 days, based on the last 12 months average.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	Recruitment time to hire for June 2022 is 77 working days, compared to 71 working days in June 2021. This includes notice periods.	The Recruitment team continues to engage with Recruiting Managers to ensure they are proactively considering, and pre-planning recruitment timelines aligned to best practice. A deep dive of time to hire is being undertaken to identify any themes regarding delay to time to hire. An action plan will be developed for targeted implementation from September 2022. NHS Jobs 3 has launched and the Trust is in the process of transferring our recruitment activity onto the new system. NHS Jobs 3 is a national system and the Trusts Recruitment team are exploring further options to improve time to hire utlising the new system. An inclusive recruitment approach continues to be promoted. Work is underway in collaboration with our OD Colleagues who have developed a line manager training programme. This includes Recruitment and EDI training to support managers in developing their knowledge and skills in the recruitment process.
63. Vacancy Rates Target: 9% or Below	UoR The Trust's vacancy rate was 10.89% in June 2022.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	The Trust Headcount is currently 4,404 (3,919 FTE) compared to 4,393 (3,901 FTE) in June 2021. The Trust is engaging with national directives such as International Nurse recruitment, AHP Return to Practice, International Fellow recruitment and potential AHP International Recruitment to address vacancies. The Trust supported internship programme is to commence in September, with Willow Green College, a year long internship with Project Search who support people with disabilities to choose their path towards education and long term paid employment. Scoping is currently underway to develop workforce plans and the information/reporting that is required to support CBUs with developing these for their areas. This is early in the planning stage currently with more detail to be developed. This will include the consideration of new roles and role redesign to address workforce supply shortages for the future.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

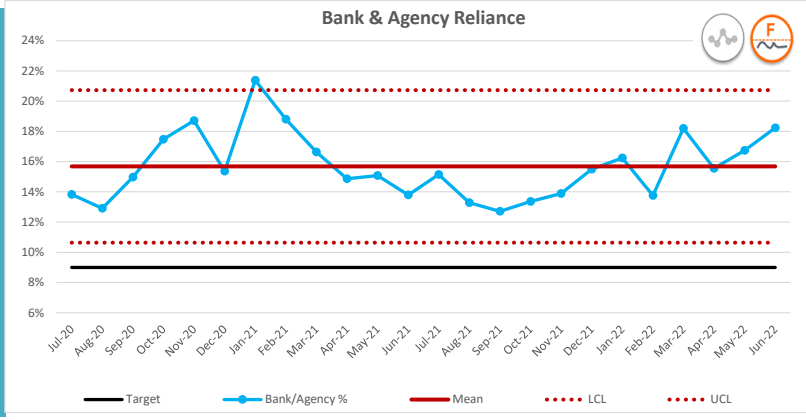
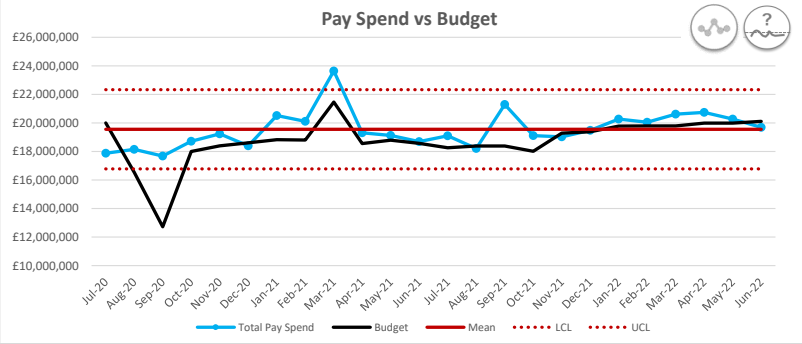
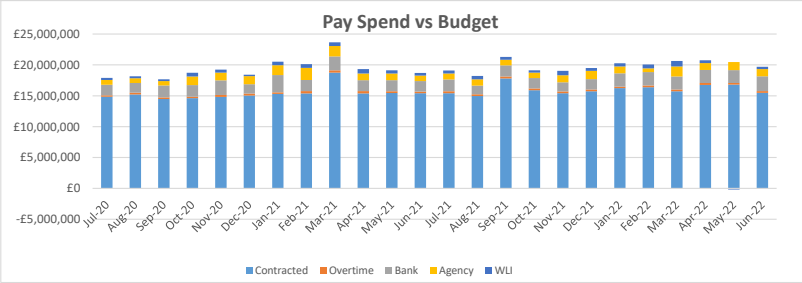
Key:
System Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
64. Retention **Target: 86%** Retention of all staff was 83.17% and Retention of Permanent staff only was 86.60% in month.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a concerning nature.	Work-life balance continues to be the number one known reason people leave WHH, followed by retirement. Analysis of the Staff Survey results is underway to understand staff opinions and suggestions for improvements, as well as identifying specific areas of WLB concerns so targeted actions can be implemented. A new Exit Interview process is being implemented to further understand the details as to why people are leaving. Collation and analysis of this data will enable themes to be identified and targeted action to be taken to address these areas. There is also further training for line managers to empower them to support their staff to remain in work and within the Trusts employment. **Work Life Balance** The Agile Working Focus Group aligned to the NHSE/I Flex for Future programme meets monthly. The purpose of the group is as follows: 1. Defining Flexible and Agile working. Understanding the legalities - Complete 2. Understand the organisation's current Agile Working/Flexible Working culture – In Progress 3. Understand the systems available to support Flexible and Agile working – In Progress 4. Develop an options appraisal for the WHH approach to Flexible and Agile working 5. Develop material to support Flexible and Agile working promotion, training and toolkits 6. Review Flexible and Agile working polices to align them to the agreed WHH approach **Retirement** A significant number of people delayed their retirement plans in 2020 and 2021, and we have now seen a significant increase in the number of individuals choosing to retire. It is worth noting a number of retirees do return to the workplace (retire and return) and are supported to do so, however these still count as a leaver for the purposes of retention and turnover. Turnover would be 14.47% if individuals who retired and returned were excluded from the calculation. **Health, Wellbeing & Development** Staff and teams continue to access the support offered by the Trusts Mental Wellbeing Team. The Organisational Development team work proactively to meet the demands of the Trust, supporting over 70 development initiatives within 2022 thus far. WHH continue to work with Rugby League Cares, providing a range of physical and mental fitness offers to the workforce. The Trusts Grief, Menopause and Autism cafes continue to take place which offer guided support sessions with both virtual and face to face offers each month.
65. Turnover **Target: Below 13%** Turnover of All staff was 16.06% and Turnover of Permanent staff only was 14.98% in month.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.		

Warrington and Halton Teaching Hospitals NHS Foundation Trust

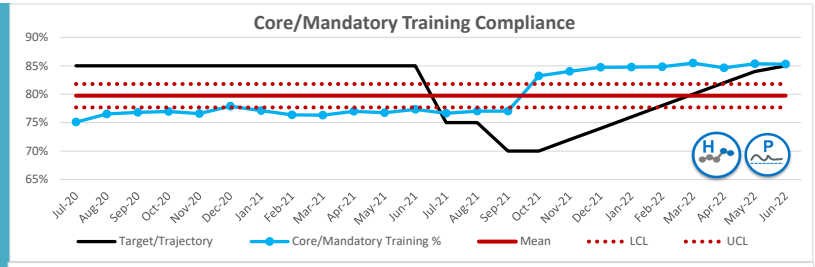
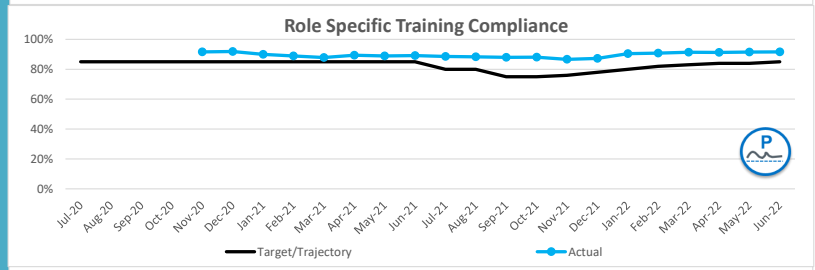
Workforce - Trust Position

Key:
System Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
66. Bank and Agency Reliance **Target: 9% or Below** UoR **Bank and Agency Reliance was 18.23% in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**Bank and Agency reliance is 18.23% in June 2022, in June 2021 it was 13.80%.**	**Processes are in place to ensure appropriate usage of temporary staffing through the ECF process and/or NHSP booking platform with the links to the Roster system.** **The interface between Patchwork (Bank) and Plus Us (Agency), is now live and is anticipated to support the improvement in Bank fill rates by removing double data entry with Patchwork as the only system to enter temporary staffing shifts onto.** **The Medical Rate Escalations process is now established which ensures oversight of usage of temporary workforce.** **Medium and long-term reduction utilisation of bank and agency staff is being supported through the development of Workforce Plans to address vacancies/workforce shortages.** **Whilst reliance on Bank and Agency is high, pay remains within the pay budget.**
67. Pay **Target: On or Less than Budget** UoR CQC S **Total pay spend in June 2022 was £19.7m against a budget of £20.1m.** UoR	 	**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**Total pay spend in June 2022 is £19.7m against a budget of £20.1m. In June 2021, pay spend was £18.6m against a budget of £18.6m.** **The total pay spend for June 2022 is made up of the following elements:** **• £15.5 contracted** **• £2.4m Bank** **• £1.1m Agency** **• £0.36m WLI** **• £0.27m Overtime**	**The additional controls and challenge for pay spend that have been identified to support a reduction in premium pay are:** **• ECF process for non-clinical vacancies approval** **• ECF process for bank and agency temporary staffing pay spend approval** **• Medical Rate Escalations approved by Medical Director** **Through the Finance and Sustainability Committee, compliance against our processes and rate cards continues to be monitored.**

Workforce - Trust Position

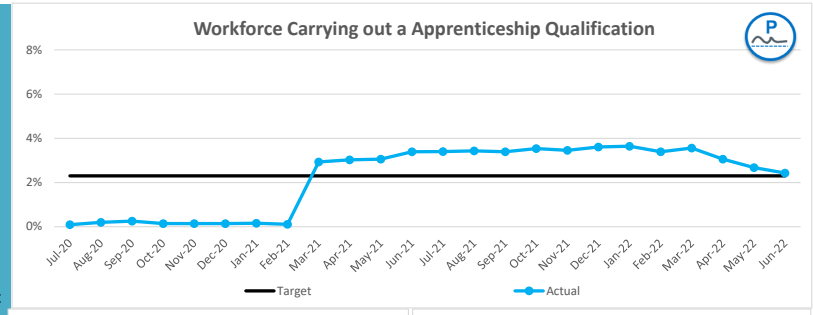
Key:
System Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR20Q)
Care Quality Commission (CQC)
Trust Strategy (S)

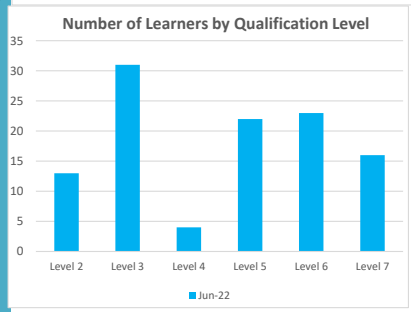
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
68. Core/Mandatory Training **Target: 85%**		**Assurance: The Trust consistently passes the target.** **Variation: Special Cause Variation of a improving nature.**	**In June 2022, CSTF Mandatory Training compliance is 85.30%, this now excludes Safeguarding Training (Children's and Adults); Safeguarding compliance is 70.67%, and Role Specific Training compliance is 91.62%.** **In June 2021, CSTF was 77.34% and Role Specific 89.16% (Safeguarding was included in CSTF).**	**Mandatory Training compliance is now split by Mandatory, Safeguarding and Role Specific Training.** **The CBUs and SMEs have been supported to develop trajectories to improve compliance, these are monitored through workforce governance structures and QPS.** **The organisation continues to support staff to access training safely with virtual offers where possible.**
69. Role Specific Training **Target: 85%**		**Assurance: The Trust consistently passes the target.** **Variation: N/A Not enough datapoints.**		
70. Safeguarding Training **Target: Trajectory**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: N/A - Not enough datapoints.**		

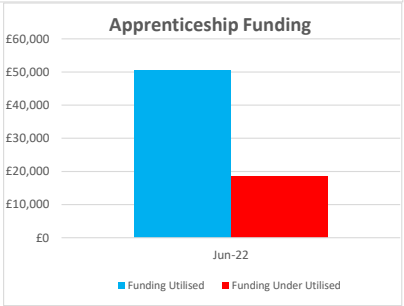
Workforce - Trust Position

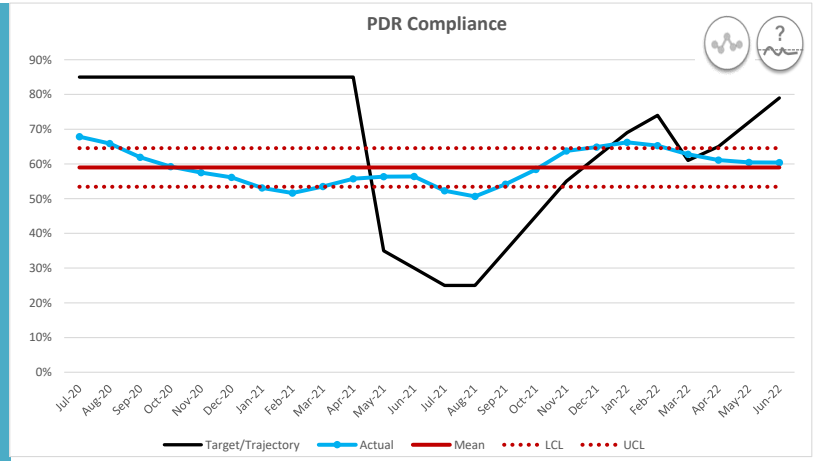
Key:
System Oversight Framework (SOF)
Use of Resources Assessment (UoR)
Risk Register (RR200)
Care Quality Commission (CQC)
Trust Strategy (S)

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
71. Workforce carrying out an Apprenticeship Qualification **Target: 2.3% or above**	**2.43% of staff were carrying out a qualification in month.**	**Assurance: The Trust consistently passes the target.** **Variation: N/A - Not enough datapoints.**	**In June 2022, 2.43% of the workforce is carrying out a qualification (previous year comparator data not available)** **Information** **Level 2 is the equivalent of NVQ Level 7 is the equivalent of a Masters** **Generally, the higher-level courses cost more, using more of the levy.** **Levy that is unspent for 24 months is returned to the DoH.**	**The ECF Panel, supported by the Trusts Apprentice Team, continues to challenge all vacancies and support managers to supplement the vacancy with an external development offer, paid for by the Levy. This supports the Trust achieving above the 2.30% target of the percentage of the workforce carrying out a qualification (2.43% in June 2022). There is also a well-developed communications programme to promote the Levy, including educating managers and staff about the various courses/development offers available through the levy.** **It is a requirement for all Recruiting Managers to consider a possibility of supplementing their recruitment offer with a development offer.**
72. PDR **Target: 85%**	**PDR compliance was 60.41% in month.**	**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**In June 2022, PDR compliance was 60.41%** **Currently PDR rates are below the trajectories.** **In June 2021, PDR compliance was 56.36%.**	**The Trust improvement trajectory aims to return to targeted compliance by July 2022. At this point, the use of the 'Check In' conversation that was implemented as part of our COVID response will end.** **The CBUs and Corporate Areas have been supported to develop trajectories and associated actions to improve PDR compliance, these are monitored through the workforce governance structures and QPS.** **The PDR talent management tool, Scope for Growth, is being trialled in three areas using a test of change approach – Digestive Diseases CBU, People Directorate and Finance Directorate. The pilot will run from July 2022 to September 2022. A training package is being delivered to these areas over July/August 2022 to include the new paperwork, and how to self-serve input the outcomes onto ESR. Outcomes of this test of change will then be reviewed to generate recommendations on a Trust wide roll out programme with the aim to improve compliance.**





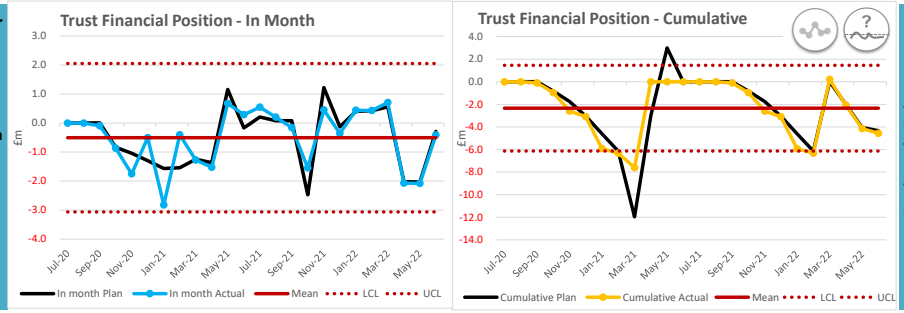
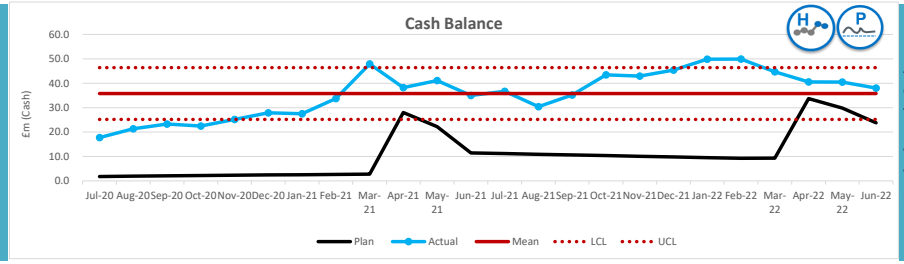
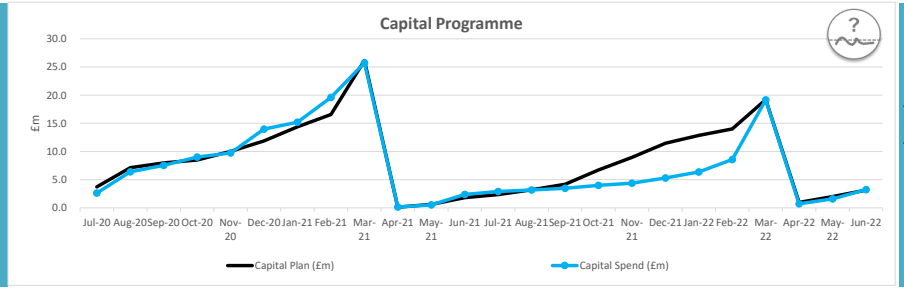




Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance & Sustainability - Trust Position

Key:
System Oversight Framework
Use of Resources Assessment
Risk Register
Care Quality Commission
Trust Strategy

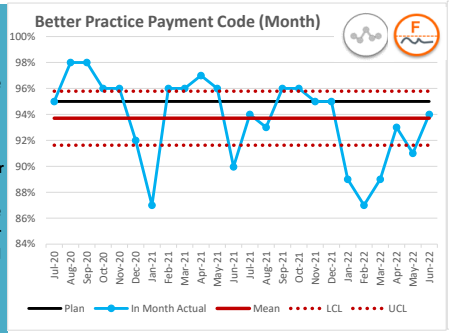
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
73. Trust Financial Position **Target: Plan**	 	**The Trust has recorded a deficit position of £4.56m which is worse than plan by £0.2m as at 30 June.**	**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**For the period ending 30 June 2022, the Trust has recorded a deficit of £4.56m, against a planned deficit of £4.34m.**	**Weekly executive meetings with Care Group and Corporate Leads have been established to oversee the identification and delivery of CIP schemes and the elective recovery programme.**
74. Cash Balance **Target: On or better than plan**		**The cash balance as at 30 June 2022 is £38.0m.**	**Assurance: The Trust consistently passes the target.** **Variation: Special Cause Variation of a improving nature.**	**The current cash balance is £38.0m which is £14.2m better than the initial cash plan. In the main this relates to a timing difference in the payment of trade creditors (£6.1m), a timing difference in the payment of capital creditors (£5.2m), additional income from contracts (£2.3m) and additional VAT recovery (£0.4m).**	**Payment of the creditors on receipt of invoices will reduce the cash back to planned levels.**
75. Capital Programme **Target: On plan 90%-100%**		**Capital expenditure year to date is £3.24m against a £3.16m plan**	**Assurance: The Trust inconsistently passes/fails the target.**	**The Trust funded annual capital plan is £13.9m of which £2.8m is to complete the ED Plaza. Capital expenditure year to date is £3.24m against a £3.16m plan. There are a further £10.2m of schemes planned which will be funded from external sources.**	**The capital programme is currently oversubscribed. The Trust is awaiting the outcome of a bid for £0.8m for CISCO system. A number of schemes have been identified to take place in April 2023 to remain within this years CDEL.**

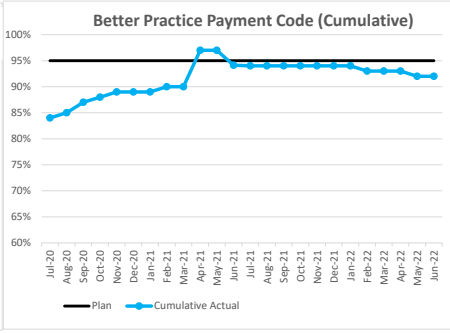
Warrington and Halton Teaching Hospitals NHS Foundation Trust

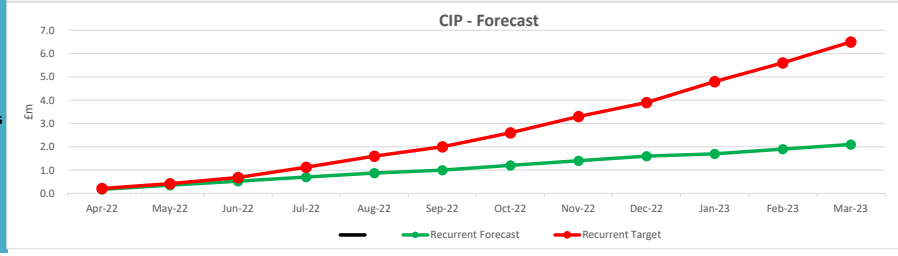
Finance & Sustainability - Trust Position

Key:
System Oversight Framework
Use of Resources Assessment
Risk Register
Care Quality Commission
Trust Strategy

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
76. Better Payment Practice Code Target: Cumulative performance 95%	The Better Payment Practice Code performance based on volume for NHS is 84.00% and non-NHS is 92.00%. The Better Payment Practice Code performance based on value for NHS is 84.00% and non-NHS is 94.00%.	Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	Cumulative performance is 92.00% which is below the national target of 95.00%.	Communications have been sent across the Trust to ensure the receipting of goods and services are recorded promptly to ensure faster payments.
77. Use of Resources Rating Target: Use of Resource Rating 1 and 2	The Use of Resources Rating is not currently being reported. The Trust is awaiting further guidance from NHSE/I.			
78. Cost Improvement Programme (recurrent & non recurrent) - In year performance to date Target: >90% Plan delivered YTD	The year to date CIP plan is £2.1m and £2.1m has been delivered.	N/A - Not enough datapoints.	In year savings identified are £14.1m against a plan of £15.7m, many of these saving are high risk and further work is needed to finalise schemes. A significant amount of the CIP programme is non recurrent which if not resolved will impact on 2023/24.	CIP progress is reviewed on a weekly and monthly basis. The Medical Director is leading the GIRFT conversations with the Operational Teams supported by Finance and the Transformational Leads to drive greater efficiency across the Trust. Weekly oversight takes place with the Executive Team.
79. Cost Improvement Programme (Recurrent Forecast) - Target: Recurrent Forecast is more than 90% of the annual target	The Trust has a recurrent CIP target of £6.1m, as at month 3, the forecast for delivery is £2.1m	N/A - Not enough datapoints.		







Appendix 4 – Trust IPR Indicator Overview

	Indicator	Detail
	Quality	
1.	**Incidents**	• Number of incidents reported in month. • Number of incidents open over 20 days and 40 days. • Number of serious incidents reported in month. • Number of serious incidents where actions have breached the timescale. • Number of never events reported in month.
2.	**Duty of Candour**	• Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Duty of Candour is where the Trust contacts the patient or their family to advise of the incident; this has to be done within 10 working days.
3. **4.** **5.**	**Healthcare Acquired Infections (MRSA, CDI and Gram Negative)**	• Meticillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. • MSSA, or methicillin-susceptible Staphylococcus aureus, is an infection caused by a type of bacteria commonly found on the skin. • Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel. • Escherichia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections. • Klebsiella is a type of Gram-negative bacteria that can cause different types of healthcare-associated infections, including pneumonia, bloodstream infections, wound or surgical site infections, and meningitis. • Pseudomonas aeruginosa can cause infections in the blood, lungs (pneumonia), or other parts of the body after surgery.
6.	**Healthcare Acquired Infections COVID-19 Hospital Onset and Outbreaks**	• Measurement of COVID-19 infections onset between 8-14 days and 15+ days of admission. • Measurement of outbreaks on wards (2 or more probably or confirmed cases reported on a ward over a 14 day period).
7.	**VTE Assessment**	• Venous thromboembolism (VTE) is the formation of blood clots in the vein. This data looks at the % of assessments completed in month, however this indicator is reported quarterly.
8.	**Inpatient Falls & Harm Levels**	• Total number of falls which have occurred in month. • Falls per 1000 bed days in month. • Total number of inpatient falls which have occurred in month. • Levels of harm reported as a result of a fall in month. • Level of avoidable harm which has occurred in month.
9.	**Pressure Ulcers**	• Pressure ulcers, also known as pressure sores, bedsores and decubitus ulcers, are localised damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction. Pressure ulcers are reported by Category (2,3 & 4).

10.	**Medication Safety**	Overview of the current position in relation to medication, to include: • Medication reconciliation within 24 hours. • Medication reconciliation throughout the inpatient stay. • Number of controlled drugs incidents. • Number medication incidents resulting in harm.
11.	**Staffing Average Fill Levels**	• Percentage of planned verses actual fill rates for registered and non-registered staff by day and night. The data produced excludes CCU, ITU and Paediatrics.
12.	**Care Hours Per Patient Day (CHPPD)**	• Staffing Care Hours per Patient Per Day (CHPPD). The data produced excludes CCU, ITU and Paediatrics.
13.	**HSMR Mortality Ratio**	• Hospital Standardised Mortality Ratio (HSMR 12 month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.
14.	**SHMI Mortality Ratio**	• Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.
15.	**NICE Compliance**	• The National Institute for Health and Clinical Excellence (NICE) is part of the NHS and is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and Wales and is recognised as being a world leader in setting standards for high quality healthcare and are the most prolific producer of clinical guidelines in the world. This indicator monitors Trust compliance against NICE guidance.
16.	**Complaints**	Overall review of the current complaints position including; • Number of complaints received in month. • Number of dissatisfied complaints in month. • Total number of open complaints in month. • Total number of cases over 6 months old in month. • Number of cases referred to the Parliamentary and Health Service Ombudsman (PHSO) in month. • Number of complaints responded to within timeframe in month. • Number of PALS complaints received and closed in month.
17.	**Friends and Family Test (Inpatient & Day Cases)**	• Percentage of Inpatients and day case patients responding as “Very Good” or “Good”. Patients are asked - Overall, how was your experience of our service?
18.	**Friends and Family (ED and UCC)**	• Percentage of AED (Accident and Emergency Department) patients responding as “Very Good” or “Good”. Patients are asked - Overall, how was your experience of our service?
19.	**Mixed Sex Accommodation Breaches (Non-ITU)**	• Number of MSA Breaches in month (outside of ITU).
20.	**Continuity of Carer**	• Better Births, the report of the National Maternity Review, set out a clear recommendation that the NHS should roll out continuity of carer, to ensure safer care based on a relationship of mutual trust and respect between women

		and their midwives. This relationship between care giver and receiver has been proven to lead to better outcomes and safety for the woman and baby, as well as offering a more positive and personal experience.
21. 22. 23. 24.	**Sepsis**	• To strengthen oversight of sepsis management in regard to treatment and screening. All patients should be screened within 1 hour and if necessary administered anti-biotics within 1 hour.
25.	**Ward Moves Between 10pm and 6am**	• Root Cause Analysis findings in relation to serious incidents has shown that patients who are transferred at night are more susceptible to a longer length of stay. It is also best practice not to move patients between 10:00pm and 06:00am unless there is a clear clinical need as research shows restful sleep aids recovery.
26.	**Acute Kidney Injury**	• Number of hospital acquired Acute Kidney Injuries (AKI) in month. • Average Length of Stay (LoS) of patients within a AKI.
27.	**National Patient Safety Alerts not completed by deadline**	• Number of CAS (Central Alerts System) alerts with actions not completed by the deadline.
	Access & Performance	
28.	**Diagnostic Waiting Times – 6 weeks**	• All diagnostic tests need to be carried out within 6 weeks of the request for the test being made.
29. 30.	**RTT Open Pathways and 52 & 104 week waits**	• Percentage of incomplete pathways waiting within 18 weeks. • Number of patients waiting over 52 weeks. • Number of patients waiting over 104 weeks.
31. 32.	**Four hour A&E Target and ICS Trajectory**	• All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge.
33.	**A&E Waiting Times – % patients waiting under 12 hours from arrival to admission, transfer or discharge.**	• % of patients who has experienced a wait in A&E longer than 12 hours from arrival to admission, transfer or discharge.
34.	**Average Time in Department (ED)**	• How long on average a patient stays within the emergency department (ED).
35.	**Cancer 14 Days**	• All patients need to receive their first appointment for cancer within 14 days of urgent referral.
36.	**Breast Symptoms – 14 Days**	• All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral.
37.	**Cancer – 28 Day Faster Diagnostic Standard**	• All patients who are referred for the investigation of suspected cancer find out, within 28 days, if they do or do not have a cancer diagnosis.
38.	**Cancer 31 Days - First Treatment**	• All patients to receive first treatment for cancer within 31 days of decision to treat.
39.	**Cancer 31 Days - Subsequent Surgery**	• All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat/surgery.

40.	**Cancer 31 Days - Subsequent Drug**	• All patients to receive a second or subsequent treatment for cancer within 31 days of decision to treat – anti cancer drug treatments.
41.	**Cancer 62 Days - Urgent**	• All patients to receive first treatment for cancer within 62 days of an urgent referral.
42.	**Cancer 62 Days – Screening**	• All patients must wait no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers.
43.	**Ambulance Handovers 15**	• % of ambulance handovers that took place within 15 minutes (based on the data recorded on the HAS system).
44.	**Ambulance Handovers 30 – 60 minutes**	• % of ambulance handovers that took place within 30 minutes (based on the data recorded on the HAS system).
45.	**Ambulance Handovers – more than 60 minutes**	• % of ambulance handovers that took place within 60 minutes (based on the data recorded on the HAS system).
46.	**Discharge Summaries – Sent within 24 hours**	• The Trust is required to issue and send electronically a fully contractually complaint Discharge Summary within 24 hrs of the patient's discharge. This metric relates to Inpatient Discharges only.
47.	**Discharge Summaries – Not sent within 7 days**	• If the Trust does not send 95% of discharge summaries within 24hrs, the Trust is then required to send the difference between the actual performance and the 95% required standard within 7 days of the patient's discharge.
48.	**Cancelled operations on the day for non-clinical reasons**	• % of operations cancelled on the day or after admission for non-clinical reasons.
49.	**Cancelled operations on the day for non-clinical reasons, not rebooked in within 28 days**	• All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days.
50.	**Urgent Operations – Cancelled for a 2nd Time**	• Number of urgent operations which have been cancelled for a 2nd time.
51.	**Super Stranded Patients**	• Stranded Patients are patients with a length of stay of 7 days or more. Super Stranded patients are patients with a length of stay of 21 days or more. The number relates to the number of inpatients on the last day of the month.
52.	**COVID-19 Recovery Elective Activity**	• % of Elective Activity (Inpatients & Day Cases) against the same period in 2019/20.
53.	**COVID-19 Recovery Diagnostics**	• % of Diagnostic Activity against the same period in 2019/20.
54.	**COVID-19 Recovery Outpatients**	• % of Outpatient Activity against the same period in 2019/20.
55.	**% Outpatient Attendances Delivered Remotely**	• Part of the transformation of outpatient care, this indicator will monitor the % of outpatient appointments delivered remotely via telephone or video consultation.
55.	**Fracture Clinic**	• The British Orthopaedic Association recommends that patients referred to fracture clinic are thereafter reviewed within 72 hours of presentation of the injury.
56.	**% Outpatient Attendances Delivered Remotely**	•
57.	**Advice & Guidance (A&G) Activity Levels**	• Number of Advice & Guidance contacts in month.
58.	**Patient Initiated Follow Up (PIFU) Activity Levels**	• Number of Patient Initiated Follow Ups (PIFU) in month.
59.	**% of zero-day length of stay admissions (SDEC)**	• % of zero length of stay admission (SDEC).

	Workforce	
60.	**Supporting Attendance**	Comparing the monthly sickness absence % with the Trust Target (4.2%) previous year.
61.	**Welcome Back Conversations**	A review of the completed monthly return to work interviews.
62.	**Recruitment Timeframe**	A measurement of the average number of days it is taking to recruit into posts.
63.	**Vacancy Rates**	% of Trust vacancies against whole time equivalent.
64.	**Retention**	Staff retention rate % over the last 12 months.
65.	**Turnover**	A review of the turnover % over the last 12 months.
66.	**Bank & Agency Reliance**	The Trust reliance on bank/agency staff.
67.	**Pay Spend – Contracted and Non-Contracted**	A review of Contracted and Non-Contacted pay against budget.
68.	**Core/Mandatory Training**	A summary of the Core/Mandatory Training Compliance, this includes: Conflict Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation.
69.	**Role Specific Training**	A summary of role specific training compliance.
70.	**Safeguarding Training**	A summary of safeguarding training compliance.
71.	**Workforce carrying out an Apprenticeship Qualification**	% of the workforce carrying out an apprenticeship qualification.
72.	**Performance & Development Review (PDR)**	A summary of the PDR compliance rate.
	Finance	
73.	**Trust Financial Position**	The Trust operating surplus or deficit compared to plan.
74.	**Cash Balance**	The cash balance at month end compared to plan.
75.	**Capital Programme**	Capital expenditure compared to plan.
76.	**Better Payment Practice Code**	Payment of non NHS trade invoices within 30 days of invoice date compared to target.
77.	**Use of Resources (Finance)**	Suspended – awaiting further guidance from NHSE/I
78.	**Cost Improvement Programme – Plans in Progress in Year**	Cost savings schemes in-year compared to plan.
79.	**Cost Improvement Programme – Recurrent)**	Cost savings schemes recurrent compared to plan.

Appendix 5 - Statistical Process Control

1.0 What is SPC?

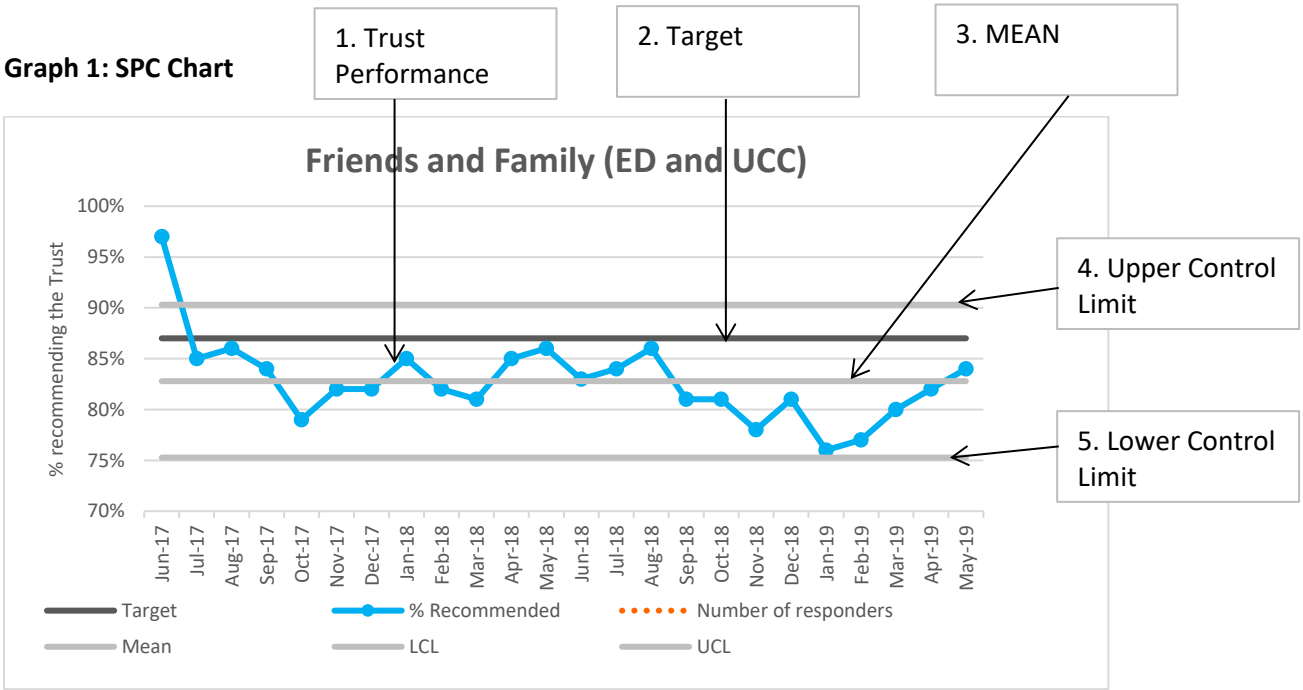
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month to month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes and both common cause (normal) and special cause (unexpected) variation.

2.0 SPC Charts

In addition to the process/metric being measured, SPC charts on the IPR have 3 additional lines.

- Mean – is the average of all the data points on the graph. This is used a basis for determining statistically significant trends or patterns.
- Upper Control Limit – the upper limit that any data point should statistically reach within expected variation. If any one datapoint breaches this line, this is what is known as special cause variation.
- Lower Control Limit – the lower limit than any data point should statistically reach within expected variation. If any one datapoint breaches this line, this is what is known as special cause variation.

Graph 1: SPC Chart

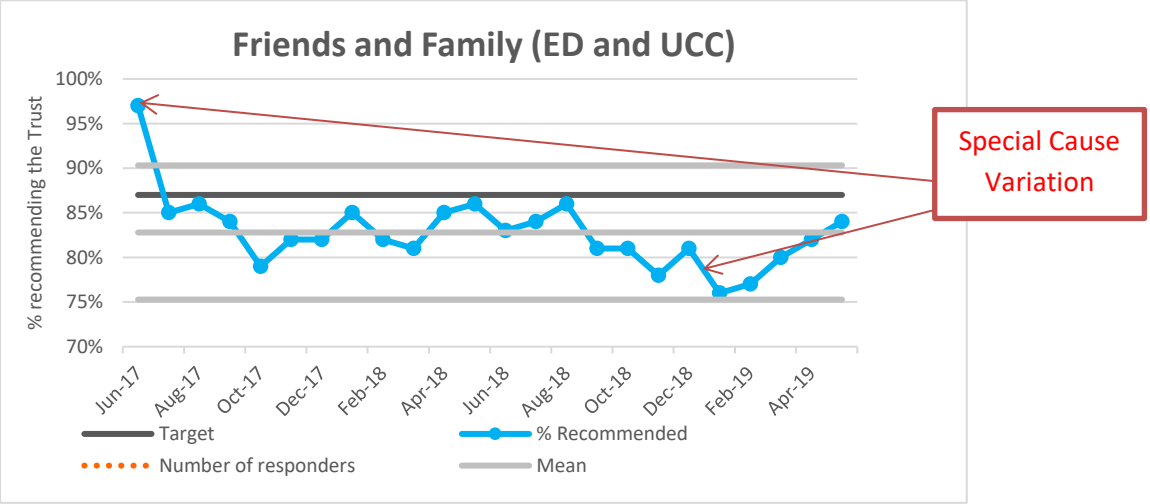


2.1 Interpreting a SPC Chart

There are 3 main rules to interpreting a SPC chart, if one of these rules is broken, this means that there is special cause variation present and that the process is not in control and requires investigation. Please note that breaching a rule does not necessarily mean the process needs to be changed immediately, but it does need to be investigated to understand the reasons for the variation.

1. All data points should be within the upper and lower control limits.
2. No more than 6 consecutive data points are above or below the mean line.
3. There are more than 5 consecutive points either increasing or decreasing.

Graph 2: Outlining Special Cause Variation



In the example above, there are two instances of special cause variation; in June 2017 the data point was outside of the upper control limit. Between September 2018 and April 2019, the data points all fall below the mean line.

For high targets (e.g. above 90%) if the upper control limit is below the target, it's unlikely the Trust will achieve the target using the current process.

For low targets (e.g. below 10%) if the lower control total is above the target, it's unlikely the Trust will achieve the target using the current process.

For the purposes of the Trust IPR, the RAG ratings (Red, Amber, Green) will be maintained to understand the Trusts current performance against the outlined targets. SPC should be considered side by side with the RAG rating as it is possible for a process to be within control but not meeting the target.

3.0 Making Data Count Assurance & Variation Icons

For 2022/23 the Trust has introduced the "Making Data Count" variation and assurance icons. These can be found in Appendix 2. Each indicator (where relevant) has been given one of the three assurance icons and one of the five variation icons which is based solely on the data and the SPC rules. Ideally the assurance icon should be blue "P" icon which notes the indicator is consistently passing its target over the last 6 months. Again, ideally the variation icon should be either the grey "common cause variation" icon or a blue "H" or "L" icon noting improving variation. The orange icons note potential concern.

Table 1: Making Data Count Assurance & Variation Icons

Assurance			Variation		
					
Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target	Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values

3.1 Business Rules

- Where there are not enough data points for an SPC chart, the target is based on a cumulative position (e.g. an annual target) or SPC is not appropriate, a "No SPC" icon is utilised as outlined below.

- Assurance icons are based on the last 6 months. E.g. if the Trust has consistently passed a target in the last 6 months the blue "P" icon will be used.
- The Variation icon is based on the last data point. If the last data point means that the one of the SPC rules described in section 2.1 of this appendix is broken, the appropriate coloured "H" or "L" icons will be used to indicate special cause variation. The variation is common cause, the grey common cause variation icon will be used.

Appendix 5

Income Statement, Activity Summary and Use of Resources Ratings as at 30th June 2022

Income Statement	Annual	Month			Year to date		
	Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income							
NHS Clinical Income							
Elective Spells	33,115	2,614	2,797	183	7,913	6,746	-1,167
Elective Excess Bed Days	354	29	1	-29	88	1	-88
Non Elective Spells	74,241	5,554	4,023	-1,532	16,421	16,517	96
Non Elective Bed Days	2,015	151	395	244	447	777	331
Non Elective Excess Bed Days	2,886	216	165	-51	640	226	-414
Outpatient Attendances	44,798	3,625	3,252	-373	10,526	8,776	-1,750
Accident & Emergency Attendances	17,871	1,937	1,834	-103	4,858	5,029	172
Other Activity	83,086	8,381	9,781	1,399	23,198	25,544	2,346
COVID Top up Income (Liverpool CCG)	34,842	2,944	2,944	0	8,711	8,711	0
Sub total	**293,208**	**25,453**	**25,192**	**-261**	**72,801**	**72,327**	**-474**
Non NHS Clinical Income							
Private Patients	0	0	-40	-40	0	3	3
Non NHS Overseas Patients	0	0	41	41	0	41	41
Other non protected	996	83	172	89	249	229	-20
Sub total	**996**	**83**	**173**	**90**	**249**	**273**	**24**
Other Operating Income							
Training & Education	9,093	758	758	0	2,273	2,273	0
Donations and Grants	2,910	-733	-2	731	117	0	-117
Miscellaneous Income	13,248	1,140	969	-172	3,062	3,560	498
Sub total	**25,251**	**1,165**	**1,724**	**560**	**5,453**	**5,834**	**381**
Total Operating Income	**319,456**	**26,701**	**27,089**	**389**	**78,503**	**78,434**	**-69**
Operating Expenses							
Employee Benefit Expenses	-233,200	-20,116	-19,444	672	-60,094	-59,927	167
Drugs	-17,585	-1,481	-1,562	-81	-4,443	-4,863	-420
Clinical Supplies and Services	-20,415	-1,761	-1,883	-122	-5,284	-5,481	-198
Non Clinical Supplies	-32,995	-2,761	-3,143	-382	-8,288	-8,476	-188
Depreciation and Amortisation	-13,760	-1,156	-1,066	90	-3,440	-3,198	242
Net Impairments (DEL)	0	0	0	0	0	0	0
Net Impairments (AME)	0	0	0	0	0	0	0
Restructuring Costs	0	0	0	0	0	0	0
Total Operating Expenses	**-317,955**	**-27,276**	**-27,099**	**177**	**-81,549**	**-81,946**	**-397**
Operating Surplus / (Deficit)	**1,501**	**-575**	**-9**	**566**	**-3,046**	**-3,512**	**-466**
Non Operating Income and Expenses							
Profit / (Loss) on disposal of assets	0	0	0	0	0	1	1
Interest Income	166	24	44	20	42	106	65
Interest Expenses	-192	-22	-16	7	-48	-47	1
PDC Dividends	-4,863	-465	-465	0	-1,216	-1,216	0
Total Non Operating Income and Expenses	**-4,889**	**-464**	**-437**	**27**	**-1,222**	**-1,156**	**66**
Surplus / (Deficit) - as per Accounts	**-3,388**	**-1,039**	**-446**	**593**	**-4,268**	**-4,668**	**-400**
Adjustments to Financial Performance							
Less Impact of I&E (Impairments)/Reversals DEL	0	0	0	0	0	0	0
Less Impact of I&E (Impairments)/Reversals AME	0	0	0	0	0	0	0
Less Donations & Grants Income	-2,910	733	2	-731	-117	0	117
Add Depreciation on Donated & Granted Assets	192	17	39	23	48	118	70
Total Adjustments to Financial Performance	**-2,718**	**750**	**41**	**-708**	**-69**	**118**	**187**
Adjusted Surplus / (Deficit) as per NHSI Return	**-6,106**	**-289**	**-405**	**-115**	**-4,337**	**-4,550**	**-212**

Activity Summary	Planned	Planned	Actual	Variance	Planned	Actual	Variance
Elective Spells	33,409	2,544	2,439	-105	7,818	7,164	-654
Elective Excess Bed Days	1,131	92	0	-92	282	2	-280
Non Elective Spells	44,866	3,318	2,156	-1,163	9,950	6,793	-3,157
Non Elective Bed Days	5,421	401	584	184	1,201	2,094	893
Non Elective Excess Bed Days	9,763	722	0	-722	2,165	764	-1,401
Outpatient Attendances	482,609	38,429	25,936	-12,493	115,432	89,347	-26,085
Accident & Emergency Attendances	108,597	10,336	10,296	-40	29,945	31,011	1,066

Appendix 6: Capital Programme
As at 30 June 2022

	Approved Programme	Budget Amendments Mths 1-2	Emergency Requests Mth 3	Proposed Budget Adjustments in Mth 3	PDC/External Funding Adjustments in Mth 3	Total Revised Budget
	2022/23	2022/23	2022/23	2022/23	2022/23	2022/23
Scheme Name	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
ESTATES						
ED Plaza	**2,859**					**2,859**
Paeds (Childrens Outpatients)	**130**					**130**
Urology (Estates)	**240**					**240**
ED Plaza further slippage	**115**					**115**
L Shaped Roof	**129**					**129**
Nurse Call Minor injuries	**25**					**25**
CMTC Replacement Emergency Lighting	**72**					**72**
ED Plaza - Dr Mess room (Exec Lead)	**141**			(141)		**0**
Breast Relocation of Breast Equipment (Kendrick to Bath Stre	**30**					**30**
Shopping City 21/22 underspend	**35**					**35**
Shopping City Retension of 2.5%	**18**					**18**
Appleton Ventilation Upgrade	**300**					**300**
Fire schemes deferred from 21/22	**300**					**300**
Estates Capital Staffing	**260**					**260**
Appleton Fire doors final phase	**200**			(200)		**0**
Dementia & Accessibility - Site Wide	**200**					**200**
Repairs to roads & footpaths across both sites	**150**			(150)		**0**
Fixed electrical testing site wide	**150**					**150**
Emergency lighting to stairwells and exits	**115**					**115**
Appleton Wing fire dampers final phase	**100**			(100)		**0**
CCTV Upgrade site wide	**50**			(50)		**0**
6 Facet Annual Survey Review	**55**					**55**
Replacement of AVSU's - part 2	**40**			**(40)**		**0**
Safe surface temperatures (radiators) final part	**30**			(30)		**0**
Annual Asbestos Site Management survey	**30**					**30**
ED Fire Barrier (actual work for above - added 28/02/2022)	**125**					**125**
Catering Upgrade	**1,800**					**1,800**
Removal of C21 Bathroom and installation of storage	**24**					**24**
Induction of Labour Ward (Lucy Gartside)	**300**					**300**
Replacement Hot Water Cylinder CSTM	**0**		13			**13**
Boiler Block 1	**0**		21			**21**
Other Slippage / VAT (TBC)				(346)		**(346)**
Estates Total	**8,023**	**0**	**34**	**-1,057**	**0**	**7,000**

IM&T						
005 Cisco Refresh (Phase 1)	**22**					**22**
007 IP Telephony	**27**					**27**
EPMA 1-4	**8**					**8**
Electronic Patient Record Procurement	**50**					**50**
Patient Flow (Tif)	**10**					**10**
Cisco Refresh Phase 2	**817**					**817**
IT Staffing	**316**					**316**
Tech Refresh 22/23	**85**					**85**
Halton SAN Refresh (DR site)	**200**					**200**
Network Switches - reduced network switches to £49k per HG	**49**					**49**
Programme and Benefits Resource/Phase 2 Structure	**165**					**165**
EPR	**155**					**155**
New Maternity System - Extended Project Management Suppo	**109**					**109**
Comms Cabinets (Phase 3)	**100**					**100**
						0
Information Technology Total	**2,113**	**0**	**0**	**0**	**0**	**2,113**
MEDICAL & OTHER EQUIPMENT						
Image Intensifer	**78**					**78**
Urology Equipment - Bladder Scanner	**10**					**10**
Video Laryngoscope	**13**					**13**
Decontamination Shelter	**2**					**2**
Hamilton Cold Vent	**0**					**0**
Radiology - Fluoroscopy Room (turnkey costs)	**105**					**105**
Mammography Equipment Replacement (enabling works only)	**50**					**50**
Video Laryngoscopes	**77**					**77**
Neonatal Scanner	**104**					**104**
Security - NEST/neonatal unit/C23/Paediatrics	**50**					**50**
Obstetric Portable Ultrasound Machine	**27**					**27**
UCC X-ray Turnkey costs	**80**					**80**
Microtomes and slide writers	**25**			3		**28**
Platelet Incubator / Agitator	**8**					**8**
Audiology ABR replacement	**22**					**22**
Resuscitaires	**91**					**91**
Replacement of the Pharmacy Automated Dispensing System	**1,084**					**1,084**
Boiling Pan - Estates and Facilities	**0**	8				**8**
A3 Dishwasher	**0**	6				**6**
Spine Coil	**0**	19				**19**
CT Scanner	**0**				200	**200**
V60 Machine - V800	**0**				130	**130**
Ophthamology	**0**				308	**308**
Echo Machines	**0**				500	**500**
						0
Medical Equipment Total	**1,826**	**33**	**0**	**3**	**1,138**	**3,000**
Total Trust Funded Capital	**11,962**	**33**	**34**	**-1,054**	**1,138**	**12,113**

CONTINGENCY						
Prior Year Adjustments (VAT Rebates)	**0**					**0**
Contingency	**802**	(33)	(34)	(354)		**381**
	0					**0**
Contingency Total	**802**	**(33)**	**(34)**	**(354)**	**0**	**381**
Total Trust Funded Capital	**12,764**	**0**	**0**	**(1,408)**	**1,138**	**12,494**
Schemes that can only go ahead if Externally Funded						
Warrington Town Deal Health and Wellbeing Hub- Capital Wo	**2,560**					**2,560**
Shopping City 21/22 underspend (added 04/02/2022)	**350**					**350**
Halton Elective Centre (TIF Funding/PDC)	**1,367**					**1,367**
Community Diagnostic Centre (CDC) - Estates	**2,400**					**2,400**
Community Diagnostic Centre (CDC) - Equipment	**3,510**					**3,510**
Total Externally Funded	**10,187**	**0**	**0**	**0**	**0**	**10,187**
Schemes that can only go ahead if further funding identified						
Appleton Fire doors final phase	**0**			200		**200**
Repairs to roads & footpaths across both sites	**0**			150		**150**
Appleton Wing fire dampers final phase	**0**			100		**100**
CCTV Upgrade site wide	**0**			50		**50**
Replacement of AVSU's - part 2	**0**			40		**40**
Safe surface temperatures (radiators) final part	**0**			30		**30**
Total of additional schemes if funding available	**0**	**0**	**0**	**570**	**0**	**570**
Grand Total	**22,951**	**0**	**0**	**-838**	**1,138**	**22,681**

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/07/88 a**			
SUBJECT:	**Staffing Assurance Report – April & May 2022**			
DATE OF MEETING:	27th July 2022			
AUTHOR(S):	Ali Kennah, Deputy Chief Nurse			
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.			x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment.			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This paper details ward staffing data for the months of April and May 2022. Ward staffing data continues to be systematically reviewed to ensure the wards and departments are safely staffed. Mitigation was provided and associated actions put in place when a ward was below 90%, minimum staffing percentage of planned staffing levels. Registered nurse and midwife sickness absence in the month of April was recorded at 8.99% an increase from the previous month which was 7.24%. Sickness data in May decreased to 7.31%. In the month of April, 14 of the 21 wards were above 90% target fill rate and in the month of May there were 15 wards. To ensure safe staffing levels are maintained, mitigation and responsive plans were implemented to ensure that there is safe delivery of patient care. Care hours per patient day (CHPPD) in April increased from 7.1 in March to 7.5 April and 7.5 in May, with a year-to-date rate of 7.5. This report provides assurance that the Trust is safely staffed, and staffing is monitored as appropriate.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of this paper.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee		
	Agenda Ref.	**SPC/21/07/79**		
	Date of meeting	20th July 2022		
	Summary of Outcome	Noted		

FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

REPORT TO BOARD OF DIRECTORS

SUBJECT	Staffing Assurance Report – April and May 2022	AGENDA REF:	BM/22/07/88 a

1. BACKGROUND/CONTEXT

Safe Staffing Assurance Report – April and May 2022.

The purpose of this report is to provide assurance with regards to the nursing and midwifery ward staffing levels during the months of April and May 2022. The Trust has a duty to ensure nursing and midwifery staffing levels are sufficient to maintain safety and provide quality care. It forms part of the expectation set out in the National Quality Board (NQB) guidance published in 2016 and in their recommendations in 2018, that Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full responsibility for nursing, midwifery and care staffing capacity and capability.

Due to the continued increased absences within the nursing and midwifery staff groups across the Trust as a result of COVID-19, existing measures remain in place to support safe staffing alongside the use of bank and agency staff to ensure safety in all areas throughout April and May 2022. A paper was presented to Trust Board in January 2022 outlining the measures in place and the results of a benchmark exercise completed to provide assurance of the plans for safe staffing in line with NHSE/I recommendations. A deep dive on staffing and the relationship to harm was presented to Quality Assurance Committee in May, which demonstrated the increase in harm linked to the reduced staffing numbers.

This paper provides assurance that shortfalls on each shift are reviewed and addressed, with actions to ensure safe staffing levels are provided and reviewed at the daily staffing meeting. Substantial evidence exists which demonstrate nurse staffing levels significantly contribute to patient outcomes (mortality and adverse events, including levels of harm), patient experience, quality of care and the efficiency of care delivery and therefore essential that the Trust delivers the right staff, with the right skills, in the right place at the right time.

2. KEY ELEMENTS

All Trusts are required to submit staffing data to NHS England via the Unify Safe Staffing return, which is a national requirement for all hospitals to publish information about staffing levels on wards, including the percentage of shifts meeting their agreed staffing levels. In addition, assurance is provided to Trust Board of Directors via the Chief Nurse and Deputy Chief Executive.

During the months of April and May 2022 ward staffing data continued to be systematically reviewed to ensure we safely staff our wards and provide mitigation and action when a ward falls below 90% of planned staffing levels.

The safer staffing data consists of the 'actual' numbers of hours worked by registered nursing and health care support staff on a shift-by-shift basis, measured against the numbers of 'planned' hours to calculate a monthly fill rate for nights and days by each ward. A monthly fill rate of 90% and over is considered acceptable nationally and within the Trust, when fill rates are below 90%, the ward staffing is reviewed at the daily staffing meeting considering acuity and activity and where necessary staff are moved from other areas to support.

In the month of April 2022, 14 of the 21 wards were above their planned 90% target of registered nursing staff for the day shift (Appendix 1&2) and in May, 15 of the wards which was an increase from April 2022. To ensure safe staffing levels, mitigation and responsive plans were implemented by the senior nursing team based on acuity and activity for the areas that did not meet 90%.

Red Flags

Staffing levels are reviewed twice daily in the staffing meeting with all areas. Red flags are created by areas where staffing levels drop below the planned establishment. A process has been put in place where red flags are reviewed, resolved, and closed at the staffing meetings, this has shown a reduction in open/unresolved red flags and provides assurance of safe staffing levels to meet the patient's needs.

Care Hours Per Patient Day (CHPPD)

CHPPD was developed, tested and adopted to provide a single, consistent and nationally comparable way of recording and reporting staff redeployment on all inpatient wards across all healthcare settings. CHPPD is the total time spent on direct patient care based on the number of occupied beds at midnight. The data is valuable because it consistently shows how well patient care requirements are met alongside outcome measures and quality indicators. The April and May 2022 Trust wide staffing data was analysed and cross-referenced, with ward level data for validation by the Deputy Chief Nurse and Lead Nurses. The senior nursing team currently collects and reports CHPPD data monthly.

Table 1 illustrates the monthly CHPPD data.

Finyear	Month	Cumulative count over the month of patients at 23:59 each day	CHPPD - Registered	CHPPD - Care Staff	CHPPD All
2021/22	Apr	13769	4.4	3.3	7.7
	May	13645	4.6	3.5	8.1
	Jun	13134	4.5	3.4	7.9
	Jul	13964	4.4	3.3	7.6
	Aug	13479	4.7	3.3	8.0
	Sep	13428	4.5	3.3	7.8
	Oct	14131	4.5	3.1	7.6
	Nov	14726	4.3	3.0	7.3
	Dec	14448	4.7	2.9	7.7
	Jan	14174	4.8	3.1	7.9
	Feb	13901	4.3	2.9	7.2
	Mar	15320	4.3	2.8	7.1
2021/22 Total		168119	4.5	3.1	7.6
2022/23	Apr	14461	4.5	3.0	7.5
	May	15060	4.5	3.0	7.5
2022/23 Total		29521	4.5	3.0	7.5

A triangulation report is now shared with all senior nurses on a monthly basis which shows red flags, RAG status for staffing levels on gold command, staffing incidents against patient harm which allows each area to be reviewed and actions put in place where themes and trends are identified.

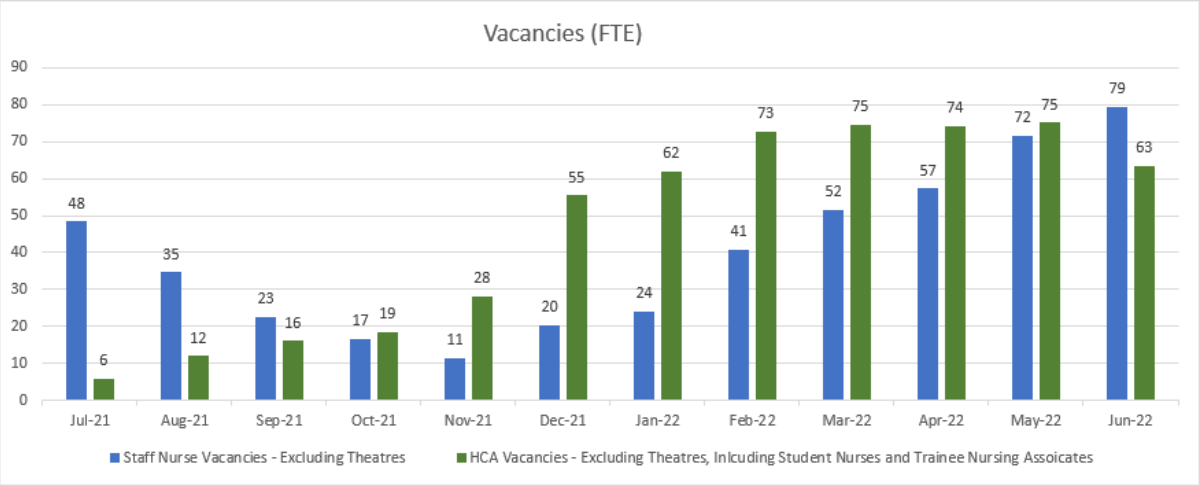
Staffing Levels and Harm

Triangulation of staffing levels with reported harm for 2021/2022 was presented at Quality Assurance Committee in May 2022 and demonstrates an increase in harm in relation to reduced staffing levels. Sickness levels across nursing groups continues to be a challenge and work with HR colleagues is ongoing as part of retention work.

Month	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
N&M Registered	7.87%	7.89%	9.06%	10.61%	7.98%	8.56%	9.08%	7.38%	7.88%
Band 2 HCSW	12.93%	13.71%	14.10%	12.56%	9.93%	11.58%	12.36%	9.39%	8.52%

Vacancy Summary

Table 2 below shows the nurse and health care assistant vacancy.



HCSW Vacancies

The above table shows an increase in HCSW vacancies Q4 21/22 which is because of successful business case approval for C21 and K25 and the 18 extra beds funding which was approved earlier in the year. In addition, the International Nurses who were employed as HCSW's have transferred into band 5 vacancies. However, this is offset by the band 5 extra vacancies generated as a result of the business cases. Of the 63 HSCW vacancies 51 of those are currently in different stages of the recruitment pipeline. More recently we have seen a reduction in the trend, which has continued into July with staff onboarding because of the work underway to reduce HCSW vacancies.

WHH has continued to work with NHSEI to achieve zero vacancy as part of the C&M recruitment programme.

Registered Nursing Vacancies

Registered nurse vacancies have increased due to the successful business case approval in relation to C21, K2, the funding for the extra 18 beds and the 30 International Nurses. Of those 79 vacancies, 54 are currently in different stages of the recruitment pipeline.

Recruitment and retention remain a priority and a workforce plan is being developed supported by the Trust HR Team so we can forecast workforce needs going forward.

Overseas Recruitment

The 30 nurses will be recruited in 2 cohorts commencing in July and September 2022.

Cohort	Expected cohort size	No. Employment offers made
Cohort 6 – July 2022	16	16
Cohort 7 – September 2022	14	14

Care Group Establishments

Unplanned Care Group

The costings for the Enhanced Care Unit on AMU are currently being calculated after the repurposing of those beds, with a wider review of nurse staffing establishments across Unplanned Care. This review includes ITU in relation to how WHH compares with the Guidelines for the Provision of Intensive Care Services (GPICS) standards for ITU staffing levels. This remains under review.

Planned Care Group

Ward B3 remains open at Halton as a facility to step down patients from Warrington site, who meet the criteria as less acute. This ward has no funded nursing establishment and as a result staff have been taken from other areas across the Trust to provide safe levels of care leaving areas reliant on temporary staffing. The costs to fund this ward are currently being calculated and within the business case process for approval imminently. Continued use of ward B3 as an escalation area with no substantive funding increases the risk across this and other clinical areas of increased harm incidents. Resulting from gaps in staffing levels and the continued use of temporary staffing.

Safer Nursing Care Tool (SNCT)

A biannual acuity and dependency review is completed using an evidence-based tool endorsed by National Institute for Health and Care Excellence (NICE). The first review for WHH was completed in June 2022 for both adult inpatients and those in the Emergency Department. The results are being analysed and will be presented to Quality Assurance Committee in August 2022.

Escalation Beds

It is important to note that the Trust continues to be extremely challenged with increased activity and as a result additional beds have been opened periodically which impacts on the staffing allocation across the Trust. Extra beds have been opened in the following areas:

- Catheter Laboratory, ward A4 and B18
- Extra beds opened on B3, in addition to the original 27 already opened as escalation.

Between 35 and 53 extra beds have been opened when necessary and the number continues to flex in response to the continued demand. The opening and use of escalation beds across the Trust places greater pressure on safe staffing requirements which is already difficult to achieve with the continued absence of staff due to sickness ,COVID -19 related issues and existing vacancies. A noted increase in harm has been seen across 2021-2022 which has correlated with the increase in escalation beds and staff absence.

Temporary Staffing

WHH is currently working with NHS Professionals (NHSP) and have recently just finished a 3-month pilot period for the provision of the Agency Managed Service (AMS) project which went live the 1st of April 2022. Early indicators of the results are favourable with a noted reduction in agency spend and the use of off framework agency staff despite the significant challenges with nurse staffing sickness and absence that has such a negative impact on the ability to fill shifts.

Table 3 below outline the number of off-framework shifts and where utilised during April and May 2022

Agency	Ward	Day	Date	Start Shift	End Shift	NoHours	NoOfHours	Rate2	Total Cost
Thornbury	ED	SUN	17/04/2022	19:45	08:00	12:15	11.75	£67.45	£792.54
Thornbury	ED	MON	18/04/2022	07:45	20:00	12:15	11.75	£67.45	£792.54
Thornbury	ED	MON	18/04/2022	07:45	20:00	12:15	11.75	£67.45	£792.54
Thornbury	ED	SUN	17/04/2022	19:45	08:00	12:15	11.75	£67.45	£792.54
Thornbury	ED	SAT	16/04/2022	07:45	14:45	07:00	6.50	£67.45	£438.43
Thornbury	ED	SAT	16/04/2022	14:45	20:00	05:15	5.25	£67.45	£354.11
Thornbury	ED	MON	18/04/2022	19:45	08:00	12:15	11.75	£67.45	£792.54
Thornbury	ED	MON	18/04/2022	19:45	08:00	12:15	11.75	£67.45	£792.54
Thornbury	ED	SUN	15/05/2022	07:15	14:30	07:15	6.75	£67.45	£455.29
Thornbury	ED	SUN	15/05/2022	07:15	14:30	07:15	6.75	£67.45	£455.29
Thornbury	ED	SUN	15/05/2022	19:30	07:30	12:00	11.50	£67.45	£775.68
Thornbury	ED	SUN	15/05/2022	19:30	07:30	12:00	11.50	£67.45	£775.68
Thornbury	ED	MON	16/05/2022	07:15	20:15	13:00	12.50	£67.45	£843.13

The above usage of off-framework agency is reflective of the gaps in staffing associated with higher total absence during the reporting period. There has been no off-framework agency fill since the 21st May 2022.

Sickness Absence – April and May 2022 and Associated Bank/Agency Costs

Registered nurse and midwife sickness absence in the month of April 2022 was recorded as 8.99% showing a decrease in May to 7.31%. The cost of bank/agency cover of qualified nursing sickness (at usual bank/agency fill rates) was £298,258 in April and £290,302 for May as detailed in the tables 4 and 5 below.

Table 4 - Registered nurse and midwifery sickness cover – April 2022

	Apr-22
Contracted Nursing WTE (Band 5to 7)	940.90
% Sickness	7.52%
WTE Equivalent of Sickness	70.76
NHSP Fill Rate	76%
WTE Covered by Temporary Staffing	53.77
Cost at Average NHSP Rates	***298,258***

Table 5 - Registered nurse and midwifery sickness cover – May 2022

	May-22
Contracted Nursing WTE (Band 5to 7)	902.60
% Sickness	7.63%
WTE Equivalent of Sickness	68.87
NHSP Fill Rate	76%
WTE Covered by Temporary Staffing	52.34
Cost at Average NHSP Rates	***290,302***

Maternity Staffing

Calculated total workforce requirement for WHH is 116.70 wte, which includes an additional 10% for non-clinical roles. The comparative current funded establishment is 122.22wte which means that whilst there is a positive variance of 5.52wte registered midwives this will help to sustain the high achievement of the current rostered model for Continuity of Carer. The overall ratio for Warrington & Halton Teaching Hospitals NHS Foundation Trust of 24.6 births to WTE in line with NICE guidelines.

In addition to the above completion of Birthrate Plus® assessment and implementation of the new Birthrate Plus® acuity App, there is an effective system of workforce planning in place to ensure safe staffing levels which incorporates:

- Oversight by the Deputy Head of Midwifery of workforce matters
- Escalation of areas of concern through a monthly high level briefing paper via the Workforce Review Group
- Daily staffing review and monitoring of safe staffing levels

- Proactive management of sickness and absence
- Reinstatement of the attendance management surgeries to assist line managers with effective management of long-term sickness absence cases
- Implementation of several initiatives to support recruitment and retention

Paediatrics and Neonatal Unit

- Funding sourced within the CBU to increase the HCSW staffing for the Paediatric Outpatients Department as a result of the increase of clinical space within the redevelopment.
- Daily sitreps continue to be submitted to the Cheshire and Mersey Paediatric Network, this report notes acuity and staffing levels as well as HDU capacity, Covid 19 and RSV admissions. There is a focus across the network on the increase of children being admitted to children's wards requiring Mental Health support.
- May and June continued to see an increased and unprecedented absence of workforce due to COVID19. This was managed by flexibility of our current staff, agency and NHSP bank shifts which was supported by the Trusts Senior Nursing Team. Due to this a reduction of staff with the QIS qualification (Qualified in Speciality) was seen which led to the NNU having to open to emergencies only during these periods. This was managed as per local escalation policy.
- As part of a recent workforce meeting with the Northwest Neonatal Operational Delivery Network we are undertaking a staffing review to move our workforce and skill mix to an optimal and compliant model.
- The Child Health Matron continues to represent WHH at the Silver command meetings for the Cheshire and Mersey Network.
- Recruitment within Neonatal Units continues to be a challenge across the region. The WHH NNU has successfully recruited 5 Band 5 staff nurses.

Therapy

- Therapies continue to review vacancies across the profession's skill mixing to support the challenges with recruitment and retention
- Exploring new roles, this includes Advanced Clinical Practitioners and apprenticeships
- Career conversations and cascading development opportunities offered by WHH
- Active management of absent and sickness, supported by the review of therapies supervision policy to embed a check in conversation culture
- High level brief report feeds into Workforce Review Group for assurance and escalate.
- Daily workforce reviews across inpatient therapy services to support shortfalls due to vacancies and escalation beds
- Total vacancies across therapy groups for both inpatient and outpatient services are 40.92. There is an even split between inpatient and outpatient services, of those

40.92, 21 are in the HR process and another date for interview is planned for early June 2022. Close monitoring of this process is maintained by the AHP Lead, Head of Therapy Services with joint working underway between nursing and AHP recruitment. AHP staff will join NHSP in July 2022 which will encourage fill of staffing gaps and support recruitment.

- Business case in progress to correctly fund current staff model, the business case will not increase the establishment.

Theatre

- At present theatres are reviewing staff requirements following covid-19, this includes leadership 7 days per week and ODP requirement levels following the increasing acute demands from the trust with critical care and AED sick patients.
- Recruitment and retention on a national scale demonstrates shortfalls in theatre staff due to retirement or lost to agencies. Theatre managers across the Northwest come together to discuss for future workforce planning.
- Engaged in the oversea recruitment for theatres
- Due to gaps in ODP staffing, alternative staffing models are being explored such as skilling up anaesthetic nurses which requires training. The recruitment team are supporting theatres with this work.
- Workforce planning demonstrates a large number of staff with retirement plans. Work is underway to succession plan
- Structure for progression from band 2 upwards and have theatre hierarchy model to support this.

3. RECOMMENDATIONS

Members of the Trust Board are asked to note the content of the report.

Appendix One – Monthly Staffing Data – April 2022

Monthly Safe Staffing Data – April 2022																			
		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night		CHPPD				
CBU	Ward	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	% RN fill rate	% HCA fill rate	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	% RN fill rate	% HCA fill rate	Cumulative count over the month of patients at 23:59 each day	RN	HCA	RNA	AHP	Overall
DD	Ward A4	1725.0	1379.8	1380.0	1403.0	80%	102%	1380.0	1322.5	1380.0	1222.5	96%	89%	1005	1.5	2.6	0.1	0.0	4.2
DD	Ward A5 G	1035.0	977.5	1035.0	980.0	94%	95%	690.0	690.0	1035.0	862.5	100%	83%	620	2.7	3.0	0.0	0.0	5.7
DD	Ward A5 E	667.0	667.0	667.0	545.0	100%	82%	690.0	678.5	690.0	264.5	98%	38%	170	7.9	4.8	0.0	0.0	12.7
MSK	Ward A6	1725.0	1598.5	1725.0	1610.0	93%	93%	1035.0	1138.5	1725.0	1437.5	110%	83%	1012	2.7	3.0	0.0	0.0	5.7
MSK	CMTC	1035.0	1196.0	690.0	621.0	116%	90%	690.0	575.0	690.0	195.5	83%	28%	187	9.5	4.4	0.0	0.0	13.8
W&C	C20	1035.0	996.5	690.0	600.5	96%	87%	690.0	690.0	0.0	287.5	100%	N/A	470	3.6	1.9	0.0	0.2	5.7
W&C	Ward C23	1380.0	1138.5	690.0	586.5	83%	85%	690.0	632.5	690.0	552.0	92%	80%	458	3.9	2.5	0.0	0.0	6.4
W&C	Birth Suite	2070.0	2495.5	356.5	310.5	121%	87%	2070.0	2369.0	356.5	253.0	114%	71%	258	18.9	2.2	0.0	0.0	21.0
W&C	The Nest	356.5	310.5	356.5	207.0	87%	58%	356.5	310.5	356.5	253.0	87%	71%	13	47.8	35.4	0.0	0.0	83.2
W&C	Ward B11	2942.5	2408.5	780.0	717.5	82%	92%	1596.0	1498.8	322.4	301.6	94%	94%	297	13.2	3.4	0.1	0.0	17.0
W&C	NNU	1725.0	1156.5	345.0	218.5	67%	63%	1725.0	1104.0	345.0	299.0	64%	87%	188	12.0	2.8	0.0	0.0	14.8
UEC	Ward A1	2254.0	2283.2	2870.8	1883.6	101%	66%	1607.2	1859.6	1269.8	898.3	116%	71%	993	4.2	2.8	0.0	0.0	7.0
UEC	Ward A2	1489.0	1349.5	1883.4	1605.2	91%	85%	971.9	1005.5	959.0	859.1	103%	90%	791	3.0	3.1	0.0	0.0	6.1
UEC	ED	6972.9	6755.7	2835.9	2642.7	97%	93%	4677.6	5377.9	2149.1	1931.4	115%	90%	0					
MC	ACCU	2415.0	2018.5	1035.0	889.5	84%	86%	1725.0	1748.0	1035.0	1000.5	101%	97%	777	4.8	2.4	0.0	0.0	7.3
MC	ICU	5520.0	5065.8	1035.0	649.8	92%	63%	5520.0	4985.3	1035.0	644.0	90%	62%	494	20.3	2.6	0.0	0.0	23.0
MC	B18	2495.5	1914.5	1426.0	1331.5	77%	93%	2139.0	1867.5	1426.0	1156.0	87%	81%	867	4.4	2.9	0.0	0.0	7.2
IM&C	Ward A7	1725.0	1437.5	1725.0	1299.0	83%	75%	1380.0	1325.0	1380.0	1240.5	96%	90%	0	-	-	-	-	-
IM&C	Ward C21	1426.0	1173.0	1426.0	1175.5	82%	82%	1069.5	1046.5	1069.5	908.5	98%	85%	731	3.0	2.9	0.0	0.0	5.9
IM&C	Ward B14	1035.0	1058.0	2070.0	1555.5	102%	75%	690.0	701.0	1127.0	989.0	102%	88%	720	2.4	3.5	0.0	0.0	6.0
IM&C	Ward B12	1035.0	1010.5	2415.0	2033.0	98%	84%	690.0	701.5	1725.0	1817.0	102%	105%	630	2.7	6.1	0.2	0.0	9.1
IM&C	Ward B19	1035.0	957.5	1380.0	1267.0	93%	92%	1035.0	747.5	1380.0	1023.0	72%	74%	720	2.4	3.2	0.0	0.0	5.7
IM&C	Ward A8	1725.0	1439.0	1725.0	1160.5	83%	67%	1380.0	1357.0	1380.0	1161.5	98%	84%	1020	2.7	2.3	0.0	0.0	5.0
IM&C	Ward A9	1725.0	1437.5	1725.0	1377.0	83%	80%	1426.0	1311.0	1725.0	1052.0	92%	61%	1020	2.7	2.4	0.0	0.0	5.1
	Total	46548.4	42224.9	32267.1	26669.3	91%	83%	35923.7	35042.6	25250.8	20609.3	98%	82%	13441	16.0	20.3	0.2	0.0	36.8
		= above 100%			= above 90%			= above 80%			= below 80%								

Appendix Two – Monthly Staffing Data – May 2022

Monthly Safe Staffing Data – May 2022																			
		Day	Day	Day	Day	Day	Day	Night	Night	Night	Night	Night	Night		CHPPD				
CBU	Ward	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	% RN fill rate	% HCA fill rate	Planned RN hours	Actual RN hours	Planned HCA hours	Actual HCA hours	% RN fill rate	% HCA fill rate	Cumulative count over the month of patients at 23:59 each day	RN	HCA	RNA	AHP	Overall
DD	Ward A4	1782.5	1380.0	1426.0	1420.0	77%	100%	1426.0	1380.0	1426.0	1380.0	97%	97%	1037	2.7	2.7	0.1	0.0	5.5
DD	Ward A5 G	1069.5	1055.0	1069.5	927.5	99%	87%	713.0	724.5	1069.5	839.5	102%	78%	656	2.7	2.7	0.0	0.0	5.4
DD	Ward A5 E	690.0	720.0	690.0	546.5	104%	79%	713.0	713.0	690.0	316.0	100%	46%	264	5.4	3.3	0.0	0.0	8.7
MSK	Ward A6	1782.5	1732.5	1759.5	1630.3	97%	93%	1069.5	1319.0	1782.5	1483.5	123%	83%	1054	2.9	3.0	0.0	0.0	5.8
MSK	CMTC	1069.5	1383.5	713.0	785.5	129%	110%	713.0	713.0	713.0	322.0	100%	45%	272	7.7	4.1	0.0	0.0	11.8
W&C	C20	1069.5	1050.0	713.0	493.0	98%	69%	713.0	713.0	0.0	280.0	100%	N/A	496	3.6	1.6	0.0	0.3	5.4
W&C	Ward C23	1150.0	1426.0	609.5	713.0	124%	117%	586.5	713.0	586.5	713.0	122%	122%	284	7.5	5.0	0.0	0.0	12.6
W&C	Birth Suite	1886.0	2139.0	333.5	356.5	113%	107%	1621.5	2139.0	172.5	356.5	132%	207%	249	17.2	2.9	0.0	0.0	20.0
W&C	The Nest	339.0	356.5	241.5	356.5	105%	148%	264.5	356.5	276.0	356.5	135%	129%	4	178.3	178.3	0.0	0.0	356.5
W&C	Ward B11	3072.5	2653.9	877.5	870.7	86%	99%	1596.0	1583.8	322.4	322.2	99%	100%	347	12.2	3.4	0.1	0.0	16.0
W&C	NNU	1782.5	1196.0	356.5	241.5	67%	68%	1782.5	1115.5	356.5	299.0	63%	84%	223	10.4	2.4	0.0	0.0	12.8
UEC	Ward A1	2320.7	2359.8	2918.0	1970.3	102%	68%	1659.6	1875.7	1320.4	917.7	113%	70%	974	-	-	-	-	-
UEC	Ward A2	1554.2	1389.9	1954.4	1713.9	89%	88%	998.1	966.5	993.8	932.0	97%	94%	889	-	-	-	-	-
UEC	ED	7224.2	7395.8	2933.8	2307.2	102%	79%	4816.7	5954.4	2219.2	1904.6	124%	86%	0					
MC	ACCU	2495.5	2171.0	1069.5	966.5	87%	90%	1782.5	1735.5	1058.0	931.5	97%	88%	816.0	4.8	2.3	0.0	0.0	7.1
MC	ICU	5704.0	5313.0	1069.5	638.3	93%	60%	5520.0	5065.8	1035.0	649.8	92%	63%	519.0	20.0	2.5	0.0	0.0	22.5
MC	B18	2495.5	1842.3	1426.0	1478.8	74%	104%	2139.0	2110.0	1426.0	1092.5	99%	77%	869	4.5	3.0	0.0	0.0	7.5
IM&C	Ward A7	1782.5	1568.5	1782.5	1360.5	88%	76%	1426.0	1437.5	1426.0	1242.0	101%	87%	1054	2.9	2.5	0.0	0.0	5.3
IM&C	Ward C21	1426.0	1222.5	1426.0	1222.0	86%	86%	1069.5	1069.5	1069.5	1058.0	100%	99%	775	3.0	2.9	0.0	0.0	5.9
IM&C	Ward B14	1069.5	1102.0	1782.5	1527.0	103%	86%	713.0	724.5	1069.5	977.5	102%	91%	775	2.4	3.2	0.0	0.0	5.6
IM&C	Ward B12	1069.5	1053.0	2495.5	2243.5	98%	90%	713.0	736.0	1782.5	1633.0	103%	92%	651	2.7	6.0	0.2	0.0	9.0
IM&C	Ward B19	1069.5	1035.0	1426.0	1047.5	97%	73%	1069.5	989.0	1069.5	980.0	92%	92%	744	2.7	2.7	0.0	0.0	5.6
IM&C	Ward A8	1782.5	1491.0	1782.5	1403.0	84%	79%	1426.0	1357.0	1426.0	1173.0	95%	82%	1054	2.7	2.4	0.0	0.0	5.1
IM&C	Ward A9	1782.5	1418.0	1782.5	1703.0	80%	96%	1426.0	1633.0	1782.5	1219.0	115%	68%	1054	2.9	2.8	0.2	0.0	5.8
	Total	47469.5	44454.1	32638.2	27922.5	94%	86%	35957.4	37124.7	25072.8	21378.8	103%	85%	15059.5	6.2	3.6	0.0	0.0	9.8
		= above 100%			= above 90%			= above 80%			= below 80%								

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/07/88 b		Trust Board	**DATE OF MEETING**	27th July 2022

Date of Meeting	7 June 2022
Name of Meeting & Chair	Quality Assurance Committee, Chaired by Cliff Richards
Was the meeting quorate?	Yes

The Committee wishes to bring the following matters to the attention of the Board:

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/22/06/147	**Patient Story – The Equal Importance of Physical & Mental Health**	The Committee heard a patient story about a patient who had been admitted to hospital with confusion and a possible infection. The story described the importance of working with a "joined up" approach, in particular with the Mental Health team, and how this had eventually led to the patient making great improvement until medically optimised for discharge. Learning had been identified that perhaps the Mental Health Team could have been involved at an earlier stage, however, support received when provided had been excellent.	**The Committee received good assurance.**	**n/a**
QAC/22/06/148	**Hot Topic – Maternity Continuity of Carer Report & Action Plan**	The Committee received the report describing the current position of the Trust in relation to implementation of Maternity Continuity of Care (MCoC) in line with the requirements of Better Births and the updated National Health Service England/Information guidance published in October 2021 and May 2022. It was noted that it Trust's plan was seen as an exemplary example and the Trust was in a better than others.	**The Committee discussed the report and received good assurance.**	**Trust Board 27.07.22**

QAC/22/06/149	**Move to Outstanding (M2O)**	The Committee received the report providing an updated position on key performance metrics monitored by the CQC. It was particularly noted that the report indicated a decline across 12 indicators which related to staff sickness, turnover, constitutional targets and effectiveness of care provision. Also noted were the outcomes of mock inspections undertaken in both UEC and Surgery, Outpatients, and Maternity. It was observed that during the UEC Mock inspection the Trust remained at risk of regulatory breach of Regulation 12	**The Committee discussed the update and received moderate assurance.**	**Trust Board 27.07.22**
QAC/22/06/153	**Abdominal Aortic Aneurysm**	The Committee received a report following the declaration of an incident on 25th May 2021 noting that a patient had been lost to follow up for further imaging of aortic aneurysm. The Committee particularly noted that the subsequent review considered 2026 patients dating back to 2013 The paper detailed that assurance processes were in place to prevent this happening in the future with a failsafe mechanism in place of an alert code and the audit would be repeated in 6 months.	**The Committee discussed the paper and received good assurance in relation to compliance with the pathway.**	
QAC/22/06/156	**Maternity Update including PMRT & MIS update**	The Committee received the quarter 4 report on Perinatal Mortality that had been completed using the new Cheshire & Merseyside PMRT template. It was noted that in quarter 4 there was one stillbirth and three neonatal deaths. Further details were provided in relation to these. It was noted that the PMRT action plan had 15/23 actions completed with the remaining eight actions due for completion in August 2022.	**The Committee discussed the update and received moderate assurance.**	**QAC October 2022**

The Committee also received the following items:

QAC/22/06/150 - Deep Dive – Maternity Governance

Matters for Approval
QAC/22/06/151 – Strategic Risk Register & BAF

QAC/22/06/152 – Complaints Annual Report

Papers to Discuss and Note for Assurance
QAC/22/06/154 – Sepsis High Level Bi-Monthly Update

QAC/22/06/157 – Medicines Management/CD Annual Report
QAC/22/06/158 – Histopathology Update

Papers to Note for Assurance
QAC/22/06/159 – Quality Impact Assessment for CIP Plans
QAC/22/06/160 – Quality Dashboard
QAC/22/06/161 – Key Discussion Points from CROC

High Level Briefing Report
QAC/22/06/162 – Patient Safety & Clinical Effectiveness Sub Committee
QAC/22/06/163 – Safeguarding Sub Committee
QAC/22/06/164 – Patient Experience Sub Committee
QAC/22/06/165 – Health & Safety Sub Committee
QAC/22/06/166 – Complaints Quality Assurance Sub Committee
QAC/22/06/167 – Patient Equality, Diversity and Inclusion Sub Committee

Closing
It was noted that Maternity Continuity of Carer Action plan, Constitutional Breaches, PMRT and AAA be highlighted to Trust Board.

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/07/88 b		Trust Board	**DATE OF MEETING**	27th July 2022

Date of Meeting	5 July 2022
Name of Meeting & Chair	Quality Assurance Committee, Chaired by Jayne Downey
Was the meeting quorate?	Yes

The Committee wishes to bring the following matters to the attention of the Board:

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
QAC/22/07/174	**Hot Topic – Arthroplasty Surgical Site Infection**	The Committee received a presentation which provided an overview of the concerns regarding an increase in elective orthopaedic Surgical Site Infections (SSIs), and next steps. The Committee noted that for the period January – December 2021, the Trust reported 3 hip replacement infections which generated concern. It was also noted a further infection on a knee replacement should also have been reported in the last quarter. A further two infections have since been identified for the period January – March 2022 (1 total hip replacement and 1 total knee replacement), It was also noted that audit of care bundles were undertaken in Theatres and looked at the compliance in orthopaedic surgery across both Halton and Warrington as well as pre-operative care bundles compliance in Orthopaedic surgery. There were no concerns highlighted on both sites other than potential scope to reduce movement further in surgical environment at CSTM. A monthly oversight group has now been set up to oversee the SSI data/validating/reporting and IPC issues.	**The Committee discussed the presentation and received moderate assurance. The committee asked that a further update be provided in six months if further deterioration was noted** **The Infection Control Committee to monitor outcomes**	**QAC 10.01.23**

QAC/22/07/175	**Deep Dive – Implementation of Medical Examiner - Community**	The Committee received a presentation which provided an overview and background in relation to the implementation of the Medical Examiner. An overview on the impact of the ME service and future expansion into the Community, noting recruitment was underway for further Medical Examiners and Officers, and it was expected that there would be a move toward electronic death certificates being issued.	**The Committee discussed the presentation and received good assurance.**	
QAC/22/07/176	**Move to Outstanding (M2O)**	The Committee received the report providing an updated position on key performance metrics monitored by the CQC. It was noted that there had been an increase in three indicators categorised as better, two worse and one as much worse. There had been no inspections during the last month, however the mock inspection for ED had a total of 89 actions, with 13 identified as urgent. To date there were 3 outstanding actions which were currently being addressed. In relation to regulatory breaches, the four received in 2019, following the CQC inspection could not be closed until the next inspection had taken place. There had been a CQC engagement meeting in May and no concerns raised. For the Human Tissue Authority inspection, this had been completed and the draft report was undergoing review for factual accuracy, which had been submitted on 4 July 2022. The accreditation for Neonatal had taken place, and had had gone well, with the Trust being awarded Amber status, with two standards identified for completion in the next 6 months.	**The Committee noted the report and received moderate level of assurance.**	**Trust Board 27.07.22**
QAC/22/07/177	**Acute Kidney Failure Injury (AKI)**	The Committee received an update on AKI following a previous presentation in November 2021. The Committee noted a number of key areas that had been put in place in order to tackle the issues and these included: • Implementation of a Consultant Led Nephrology service and education programmes rolled out across the Trust. • AKI hot clinic operating outside of SDEC.	**The Committee discussed the update and received a good level of assurance.**	**QAC 10.01.23**

		• AKI role in the Acute Care Team to commence in August.		
QAC/22/07/177	**Patient, Service Users and Carers Diversity, Inclusion and Belonging Strategy 2022-25**	The Committee received a paper providing an update on the design, engagement and subsequent monitoring undertaken to create the Patient, Service User and Carers Diversity, Inclusion and Belonging Strategy for 2022-2025. It was noted that the strategy will continue to deliver against progress made between 2019-2022 to improve patient experience and create an inclusive healthcare environment for communities to access the services they need.	**The Committee discussed the update and received a good level of assurance.**	

The Committee also received the following items:

Matters for Approval
QAC/22/07/178 – Strategic Risk Register & BAF

Papers to Discuss and Note for Assurance
QAC/22/07/180 – Infection Prevention Control Annual Report
QAC/22/07/181 – Infection Prevention Control Bi-monthly BAF
QAC/22/07/182 – Clinical Audit Annual Report
QAC/22/07/183 – Maternity Update included:

- Annual Perinatal Mortality Report
- Q2 Perinatal Mortality Review Report
- Birth Rate Plus Report
- Maternity Incentive Scheme Update

QAC/22/07/184 – Quality Account Submission

High Level Briefing Report
QAC/22/07/186 – Patient Safety & Clinical Effectiveness Sub Committee
QAC/22/07/187 – Risk Review Group
QAC/22/07/188 – IG Corporate Records
QAC/22/07/189 – Quality Academy

Papers to Note
QAC/22/07/191 – Committee Chair's Annual Report

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/07/88 (c)		Trust Board	**DATE OF MEETING**	27th July 2022

Date of Meeting	20th July 2022
Name of Meeting & Chair	Strategic People Committee, Julie Jarman
Was the meeting quorate?	Yes

The Committee wishes to bring the following matters to the attention of the Board:

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/ mandate to receiving body	Follow up/ Review date
SPC/22/07/66	**Hot Topic – CDC Workforce**	The Committee received a detailed presentation and assurance regarding the workforce plans aligned to the Community Diagnostic Centre.	**The Committee noted the presentation and received good assurance. There is a significant challenge, but plans put in place for staffing are robust**	**Not applicable**
SPC/22/07/66	**Hot Topic – Inclusive Working, Agile Working**	The Committee received a presentation which focussed on the Trusts' Inclusive Working, Agile Working project In summary: • Inclusive working (Flexible and Agile) is already in WHH • Triangulation of data complete, linking flexible working, morale, and key People KPIs • Next steps to collect qualitative data to further understand the Trusts' approach to Agile Working	**The Committee noted the presentation and received moderate assurance on plans as the project is not yet fully developed.**	**SPC November 2022**

		• Highlighted the importance of expectation management, Agile Working will look different depending on role and service – guided by a set of principles and a toolkit • Identified the need for cultural change support from organisation senior leadership team to support Agile Working		
SPC/22/07/68	**Chief People Officer Report**	The Committee received a paper summarising a number of key people related topics. The group noted the cessation of temporary sickness absence terms and conditions for Covid from 7th July 2022 for new absences, and 1st September 2022 for absences prior to 7th July 2022. The group held a discussion relating to the new Pay Award announced 19/07/2022, further detail expected from the National team.	**The Committee discussed the report and received good assurance on the topics.**	**SPC September 2022**
SPC/22/07/69	**Move to Outstanding Red Flags Report**	The Committee received the Moving to Outstanding Red Flags Report. The report was noted, and the committee challenged the CQC Insight RAG ratings. There was an action to address this with the CQC.	**The Committee noted the report and received moderate assurance due to queries regarding the data from CQC.**	**SPC September 2022**
SPC/22/07/72	**BAF & Risk Register - Staff**	The Committee received the BAF and Risk Register report. The Committee agreed the change of wording to the BAF risk.	**The Committee supported the proposed changes and received good assurance**	**SPC September 2022**
SPC/22/07/77 SPC/22/07/78	**Workforce Race Equality Standards and Workforce Disability Equality Standards**	The Committee received the Workforce Race Equality Standards and Workforce Disability Equality Standards reports for 2021/22. The reports were noted and particularly the action to undertake a campaign to address the level of bullying and harassment that emerged in the Staff Survey with a focus on staff with a disability or from a minority ethnic background	**The Committee noted the report and received good assurance regarding the action plan.**	**SPC September 2022**

The Committee also received the following items:

Matters to Discuss for Assurance
SPC/22/07/70 - Employee Relations Report
SPC/22/07/71 - WHH People Strategy Report & Strategic Projects (People) including Equality, Diversity and Inclusion Strategy Update

Matters for Approval
SPC/22/07/73 - Cycle of Business Annual Review
SPC/22/07/74 – Facilities Time Off Annual Report

SPC/22/07/75 - University of Chester WHH SLA for Student Placements
SPC/22/07/76 - Policies and Procedures Report – Polices ratified:

- Flexible Working Policy, Study & Professional Leave Policy for Non-Training Grade Medical and Dental Staff, Equality, Diversity & Inclusion Policy

Matters to Note for Assurance
SPC/22/07/79 - Staffing Assurance Report April & May 2022 – Key Issues
SPC/22/07/80 - VIP & Celebrity Visits Policy & Annual Report

Sub-Committee Minutes/Notes
SPC/22/07/81 - Operational People Committee (16.06.22 & 11.07.22)
SPC/22/07/82 - Workforce Recovery Subgroup (meeting stood down)
SPC/22/07/83 - Workforce Equality Diversity & Inclusion Sub-Committee (13.06.22)

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/07/88 d		TRUST BOARD OF DIRECTORS	DATE OF MEETING	27 July 2022

Date of Meeting	**22 June 2022**
Name of Meeting + Chair	**Finance and Sustainability Chaired by Terry Atherton**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
		Matters to discuss and note for assurance		
FSC/22/06/99	Pay Assurance	The Committee considered and reviewed the report noting: - • The addition of estimated absences across the organisation by staff group to highlight where more staff are being used • Reasons for use of temporary staff reviewed including escalation beds and the acuity of patients, eg COVID patients not in ICU but very poorly. • 2 cohorts of 15 nurses joining the Trust • Monitoring of annual leave management (AFC only at this stage), to ensure staff are taking their leave and this also supports CIP achievement. • Work continues on the medical rate card and review of compliance is ongoing • Agency utilisation review - no shifts can be booked direct from agency they must go to the bank first.	The Committee **noted** the report	FSC July 2022

FSC/22/06/100	CIP & GIRFT	The Committee considered and reviewed the monthly CIP & GIRFT report noting: - • Revised target of £15.7m for 2022/23 with additional £3m income also required and all future bids to contribute • Delivered £1.2m against a plan of £1.4m • Identified £7.4m to date • Delivery is being owned across the organisation • Since writing the report significant work has taken place by the care groups to progress identification and costing of schemes	The Committee **noted** the report.	FSC July 2022
FSC/22/06/101	Digital Services Report	The Committee considered the report noting • An update to EPR project. Potential funding streams available and likely to require matched funding. • The risk of the Anti-virus protection operating at a reduced level on the PACS system and note the plans to move to alternative system. • Revised governance arrangements	The Committee **noted** the update The Committee **approved** the proposed changes to Digital governance arrangements	FSC July 2022
FSC/22/06/102	WLI MIAA Audit Review	The Committee noted the update • On the progress of the audit recommendations • Moving WLI to Payroll will improve controls • New processes will go live July • Follow up from MIAA August	The Committee **noted** the update	FSC July 2022
FSC/22/06/103	Monthly Finance report	The Committee considered the report and capital proposals. Key points to note included: • Month 2 position of £4.15m deficit, slightly worse than plan • Still using a draft activity baseline, the final baseline is not confirmed. Based on the draft baseline, the Trust did not achieve ERF in month 2 • CIP slightly behind plan in month 2 (£0.2m from plan ytd) • Agency is higher than same period last year	The Committee **noted** the update The Committee **supported** the changes to the plan for additional capital from the bids and **support** the changes	FSC July 2022 Trust Board June 2022

		• Non Pay – some High cost drugs have reduced in price and benefit share will be discussed with commissioners • Board has approved a £6.1m deficit control total to support the C&M system position, further work required to manage the organisational and system risk • Capital changes relating to successful bids • Note the items escalated from CPG and FRG	to the capital contingency	
FSC/22/06/104	Runcorn Town Deal Business Case	The Committee considered and supported the presentation noting: - • The draft capital and revenue implications • Discussed the need to undertake more activity to offset the revenue implications • The need for formal sign up of all partners • Start date April 2023 with completion April 2024 • Business case is being developed by company through the council	The Committee **noted** the presentation and **support** the business case to be presented to Board for approval	Trust Board June 2022
FSC/22/06/105	Private Patient	The Committee considered and reviewed the policy noting: - • The policy has been to and was approved by the policy review group	The Committee **noted** the updated policy	
FSC/22/06/106	Capital Planning Group Annual Report	The Committee considered and reviewed the annual report noting:- • The work undertaken by CPG during the year	The Committee **approved** the report	FSC June 2023
FSC/22/06/107	WLI Business Case	The Committee discussed and reviewed the business case noting:- • Paper is for medical and dental staff • Paper covers increase in cost and activity for 2022/23 • Discussed the risk of inflating prices further along with the need to increase the pace of recovery	The Committee **support** the business case to be presented to Board for approval	Trust Board June 2022
FSC/22/06/108	Clinical Excellence Awards Business Cases	The Committee discussed and reviewed the business case noting:- • This is a contractual requirement	The Committee **support** the business case to be presented to Board for approval	Trust Board June 2022

FSC/22/06/109	Capital Expenditure Update	The Committee considered and reviewed the presentation noting: - • The current plan for 2022/23 £23m and the overcommitment against the CDEL has reduced to £0.6m • The successful bids of for back log maintenance and other schemes • Month 2 position is underspent and the current contingency level • The progress of the schemes over £500k noting the underspend on ED plaza against budget at this point. • Shopping city highlighted a risk of an overspend of £27k for which mitigations need to be found • Need to monitor quotes and costs to understand differences from plan	The Committee **noted** the update and **supported** the changes to the capital plan to be presented to Board	FSC July 2022 Trust Board June 2022
FSC/22/06/110	Risk Register & BAF	The Committee considered the report noting: - • Approval of reducing the risk rating for risk 1290 linked to BREXIT • Risk 1372 wording proposed to be updated • The capital risk has been updated on the corporate risk register this requires further review now the CDEL gap has been reduced, with a focus on delivery	The Committee **noted** the Risk Register and BAF report	FSC July 2022

BOARD OF DIRECTORS CHAIR'S COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/07/88 e		Trust Board	DATE OF MEETING	27 July 2022

Date of Meeting	**21 June 2022**
Name of Meeting + Chair	**Clinical Recovery Oversight Committee (CROC) Chaired by Terry Atherton**
Was the meeting quorate?	**Yes**

REF	AGENDA ITEM	ISSUE AND LEAD OFFICER	Recommendation / Assurance/Decision/ mandate to receiving body	Follow up/ Review date
CROC/22/06/70	Harm Profile update	• 446 patients have a 52+ week wait and require a harm review. Planned surveillance patients are now included in the figures as these patients will require a harm review. • 1061 patients have a wait of less than 52 weeks, and require a harm review to be undertaken, this is a slight decrease on the previous month. • There have been no new cases of harm identified.	The Committee noted the update	Standing agenda item
CROC/22/06/71	Corporate Performance Report	Key points to note for May 2022: • ED performance remained below national standard of 95% • First two weeks of month were challenging due to closure of care homes in area. • B3 fully escalated. • Cath Lab utilised. • B4 usage has negative effect on day surgery. • Stranded and super-stranded patients on the last day of the month was 145.	The Committee noted the update	Standing agenda item

		• RTT target of 90% not attained but increase on previous month to 68.76%. • Outpatients DNA rate increase in May to 9.78% (face to face). • Average Length of Stay increased from 2.56 to 3.58. • Diagnostic target was not achieved, new trajectory plan has been agreed. • Cancer – Trust currently on track and meeting the trajectory for patients 104+. • Patients waiting over day 62 is currently 4 patients over trajectory. • Cancer PTL is routinely 300 patients larger than the previous 2 years. • 62 day performance is 76.9% which is a continued performance.		
CROC/2022/06/72	Waiting List updates	DM highlighted the key points. <u>RTT update – Key Points;</u> • May's total RTT Waiting List position was 28756 against a trajectory of 27656, reasons include increase in referrals in both CFT, urgent and routine. • Ophthalmology first main surgical specialty to achieve standard since pandemic at 92.25%. <u>Priority code and Waiting Time</u> • P2 Patients estimated backlog June 253. 104 Week Wait; • Estimated position is 22 against a target of 16 due to 9 patients not able to be dated. • 7 of these patients are P6. <u>Cancer: Key Points;</u> • >104 day being achieved in line with the Cancer Alliance trajectories-currently 3 patients over day 104.	The Committee noted the report.	Standing agenda item

		• >62 trajectory currently 23, which is a decrease to the previous week, this Trust is not deemed to be a risk at Cancer Alliance level. This trajectory may have to be reviewed for 2022/23 to include patients who do not have cancer but are waiting to be told-cancer ruled out (CROs). Work is going on at Alliance level to understand the impact. Levels of patients over day 62 are rising across the patch and are reflective of overall growing PTL size due to increased referrals. **<u>Diagnostics</u>** <u>Radiology – Key Points</u> • Ultrasound reporting performance is good, X-Ray figure down due to staffing issues. • Outsourcing has been switched off. Cardio Respiratory • DM reported that there has been an increase in referrals for Out Patients. <u>ECHO</u> • Staff sickness and 2 month delay in clinical coding. <u>Endoscopy – Key Points</u> • Current waiting list of 1289 patients. • In month increase of 47 patients. • Achieved highest in-month activity since 2019/20. • Month on month additions to WL continues to increase.		
CROC/2022/06/74	Access to recovery fund update	JH advised that the Trust has not assumed any ERF monies for April or May, however this could change depending on the final figures after freeze date. In addition the calculation is currently based on a draft baseline which has yet to be finalised by the national team. June activity is looking like the Trust will achieve ERF for June.	The Committee noted the update	Standing agenda item

BOARD OF DIRECTORS COMMITTEE ASSURANCE REPORT

AGENDA REFERENCE:	BM/22/07/87 (e)	COMMITTEE OR GROUP:	Trust Board	DATE OF MEETING	27 July 2022

Date of Meeting	16 June 2022 & 24th June 2022 (Extra-ordinary Audit Committee)
Name of Meeting & Chair	Year End Audit Committee, Chaired by Michael O' Connor
Was the meeting quorate?	Yes

The Committee wishes to bring the following matters to the attention of the Board:

Agenda Reference	Agenda Item	Issue and Lead Officer	Recommendation / Assurance/mandate to receiving body	Follow up/ Review date
AC/22/06/45	**External Auditors Findings Report**	16th June 2022 - The Committee received the draft Audit Finding Report noting that the audit was not yet complete; however, work was ongoing to work through outstanding issue. Headline issues were highlighted, and no areas of concern raised. 24th June 2022 – Following completion of the Audit an unqualified audit opinion and concluded that the Trust would continue as a going concern.	**16.06.2022 - The Committee discussed the report and the headline issues highlighted. If was agreed a further Extra-Ordinary meeting would take place on 24.06.2022 when the report would be approved by Chair's action if appropriate.** **24.06.2022 – The Audit Finding Report was approved by Chair's actions with good assurance received.**	**Audit Committee 18.08.22**

AC/22/06/46	**Draft Annual Report**	The Committee received a Draft of the Trust Annual Report for 2021/22, there would be further amendments and additional information to be added and a final report would be presented to the next meeting.	**The Committee noted the contents of the Draft Annual Report and received good assurance**	**Audit Committee August 2022.**
AC/22/06/47	**Final Accounts**	The Committee noted the amendments to the schedules and approved the Final Accounts, subject to any further Audit findings being added.	**The Audit Committee reviewed and approved the 2021-22 Final Audited Annual Accounts and TAC Schedules and received good assurance**	**n/a**
AC/22/06/48	**TAC Summarisation Schedules**	The Committee approved the TAC Summarisation Schedules and Certificate.	**The Committee approved the TAC Summarisation Schedules & Certificate and received good assurance**	**n/a**
AC/22/06/49	**Code of Governance Compliance**	The Committee noted that the Code of Governance would be included in the Annual Report. It was noted that one area relating to external evaluation being undertaken every three years, had not been undertaken due to the pandemic. However, the Good Governance Institute would be undertaking this over the coming months.	**The Audit Committee reviewed and approved the assurance report and approved declaration of compliance with the provisions of the Code in the Annual Report 2021-22 and received good assurance**	**n/a**
AC/22/06/50	**Compliance with Licence Annual Return**	The Committee received the Trust's Licence Annual Return – FT4 statement of compliance declaration. It was noted that the Trust does not consider itself to be in breach of is provider license and declares continued compliance, no material risks had been identified. Periodic monitoring will continue and any material changes report to the Audit Committee and the licence published on the Trust website	**The Audit Committee noted good assurance provided of full compliance with the Trust Provider Licence conditions and Certificate of Compliance.**	**n/a**

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/07/89**	
SUBJECT:	**Moving to Outstanding Action Plan Update**	
DATE OF MEETING:	27th July 2022	
AUTHOR(S):	Layla Alani, Director of Integrated Governance and Quality	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#224** Failure to meet the four hour emergency access standard and incur recordable 12-hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience. **#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#1272** Failure to provide a sufficient number of beds caused by the requirement to adhere to social distancing guidelines mandated by NHSE/I ensuring that beds are 2 metres apart, resulting in reduced capacity to admit patients and a potential subsequent major incident. **#1289** Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm. **#115** Failure to provide adequate staffing levels in some specialities and wards. Caused by inability to fill vacancies, sickness. Resulting in pressure on ward staff, potential impact on patient care and impact on Trust access and financial targets. **#134** Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. **#1134** Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain **#1125** Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance	

	#1233 Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience, delays in treating patients and increased admission to the surgical bed base. **#125** Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Moving to Outstanding Steering Group provides an updated position on key performance metrics monitored by the CQC enabling focused improvement and assurance of compliance across a number of domains. The CQC Insight Report, was expected to be provided to WHH in May 2022. This was delayed, hence the data provided in this report was not discussed at the Moving to Outstanding Steering Group Meeting on 23 June 2022. The updated position (May 2022) is provided within this report and notes the following across 77 indicators: • 9 (12%) noted as better (CQC descriptor). • 3 (4%) noted as worse (CQC descriptor). • and 1 (1%) noted as much worse 9 (CQC descriptor). When compared to the CQC Insight Report from March 2022, there is: • An increase of 3 indicators (from 6 to 9) categorised as better. • An increase of 2 indicators (from 1 to 3) categorised as worse. • A static position of the indicator (1) categorised as much worse. (**Detail provided in Section 2.1.1**) According to the CQC Insight Report declining indicators remain across: • Staff sickness. • Staff turnover. • Constitutional targets. • Effectiveness of care provision. Internal performance data is provided up to the end of May 2022 within the Red Flags Report. In line with the mock inspection schedule, no inspections have taken place in the last month. For the Emergency Department (ED) whilst action has been taken to mitigate risk, crowding and the risk of clinical deteriorating remain a concern due to system challenges relating to capacity and capability (CQC Regulation 12). The CQC engagement meeting was undertaken on 24 May 2022. No concerns were expressed.

	The Human Tissue Authority Inspection has been completed. A draft report has been received which is under review for factual accuracy. (**Section 2.14.1**) The UK Accreditation Service are reviewing the Trust's laboratories from July – August 2022. All actions are on track for these visits. The Royal College of Paediatric and Child Health Diabetes Peer Review draft report has been received. This is under review for factual accuracy (**Section 2.14.2**). An Ockenden 1 Insight visit is scheduled from NHSE/I for 29 July 2022. All actions are on track for this visit.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note x	Decision
RECOMMENDATION:	The Board of Directors are asked to note the contents of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Moving to Outstanding Steering Group Quality Assurance Committee		
	Agenda Ref.	**M2O/22/06/062 - M2O/22/06/076** **QAC/22/07/176**		
	Date of meeting	23 June 2022 4 July 2022		
	Summary of Outcome	To share with the Trust Board		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Moving to Outstanding Action Plan Update	AGENDA REF:	BM/22/07/89

1. BACKGROUND

The Moving to Outstanding Steering Group provides detail on key performance metrics monitored by the CQC, enabling focused improvement and assurance of compliance across a number of domains.

The CQC Insight Report was expected in May 2022. This was delayed. The late receipt of this report resulted in the reports presented at the Moving to Outstanding Steering Group being based on internal data in line with the Trust's Red Flag reporting process. The data from the CQC Insight Report received in June 2022 is being shared within this report to enable timely sharing of information, alongside Red Flag data for May 2022.

The report also provides an update on WHH plans for CQC preparedness, an update on mock inspections and information about the CQC Engagement Meeting on 24 May 2022.

2. KEY ELEMENTS

2.1 CQC Insight Position and Red Flags Report

2.1.1 CQC Insight Report

The CQC Insight Report from June 2022 monitored Trust performance across 77 indicators. In the previous reporting period, March 2022, 71 indicators were monitored by the CQC (increase of 6). The number of indicators changes month by month depending on data assessed by the CQC in each CQC Insight report. Overall Trust wide performance remained stable. Of the 77 indicators monitored:

- 9 (12%) were noted as better
- 3 (4%) were noted as worse
- and 1 (1%) were noted as much worse.

When compared to the CQC Insight Report from March 2022, there is:

- An increase of 3 indicators (from 6 to 9) categorised as better
- An increase of 2 indicators (from 1 to 3) categorised as worse (declined position)
- A static position of the indicator (1) categorised as much worse

Table 1 shows the performance of the indicators categorised as better, worse and much worse compared to the national average position in accordance with the June CQC Insight Report 2022 (including staff survey results April 2022).

Table 1

Indicator	Latest Performance	National Average	Variance
Proportion of staff that believe they have adequate materials and resourcing, and that they have adequate staff (%)	59.36% (Sep 21 - Dec 21)	55.46%	+ 3.9%
Flexible working	6.1 (Sep 21 - Dec 21)	6.0	+ 0.1
Morale	5.9 (Sep 21 - Dec 21)	5.7	+ 0.2
Proportion of staff who have felt burnt out due to work (%)	31.25% (Sep 21 - Dec 21)	35.33%	+ 4.08%
Proportion of staff who would feel secure raising concerns about unsafe clinical practice (%)	77.52% (Sep 21 - Dec 21)	73.57%	+ 3.95%
Recognised and rewarded	6.1 (Sep 21 - Dec 21)	5.8	+ 0.3
Safe and healthy	6.1 (Sep 21 - Dec 21)	5.9	+ 0.2
Sick days for medical and dental staff [set target 3.5%] (%)	2.23% (Apr 21 - Mar 22)	1.75%	+ 0.48%
Voice that counts	6.9 (Sep 21 - Dec 21)	6.7	+ 0.2
Proportion of Staff Doing Paid Overtime (%)	43.15% (Sep 21 - Dec 21)	38.15%	- 5%
We are always learning	5.1 (Sep 21 - Dec 21)	5.2	- 0.1
GMC - Enhanced monitoring	Status: no concern with progress May 22	No enhanced monitoring	N/A
Proportion of staff appraised (%)	67.36% (Sep 21 - Dec 21)	79.08%	- 11.72%

Key:

Colour	Categorisation
	Better than national average
	Worse than national average
	Much worse than national average

In relation to the indicators categorised as worse and much worse:

- GMC Enhanced Monitoring has been a Red Flag Indicator for over a year whilst improvement work has been undertaken. Internal and CQC Insight Data shows improvement in performance. The GMC trainee survey is underway and the Trust are awaiting is awaiting the results. The next internal monitoring meeting is scheduled for 7 July 2022 when the GMC results are expected to be available to inform next steps. Robust plans are in place to ensure improvement and sustainability monitored by Medical Cabinet, the Workforce Review Group and Strategic People Committee.

2.1.2 Red Flags Report

For the purposes of the 'Red Flag' update within this report, data from the CQC Insight Report received in June 2022 has not been included by means of comparison due to late receipt of the report. An

accuracy review is undertaken following receipt. This is underway and will be shared at the Moving to Outstanding Steering Group Meeting on 21 July 2022.

In April 2022 there were 32 Red Flag indicators. This position remained static in May 2022. In April 2022 there were 12 Red Flag indicators showing a decline. This position improved in May 2022 to 10 Red Flag indicators. Areas of decline have remained the same in previous reporting periods and are detailed in **Table 2.** The thematic cluster remains the same with focus on:

- Sickness
- Staff turnover
- Constitutional standards (excluding ED)
- Effective care provision.

Effective care provision means patients' care and support achieves good outcomes. Actions to address these themes are denoted in **Appendix 1.**

Table 2 – Indicators showing a decline based on internal data

Indicator	Performance reported April 2022	Performance reported May 2022	Variance
Trust wide: Sick days for non-clinical staff (%)	6.37%	6.89%	+0.52
Trust wide: Sick days for other clinical staff (%)	7.6%	7.66%	+0.06
Trust wide: Sick days for nursing and midwifery staff (%)	7.18%	9.11%	+1.93%
Trust wide: Turnover rate for nursing and midwifery staff (%)	14.14%	14.66%	+0.52%
Surgery: Cancelled operations not treated within 28 days of non-clinical cancellation (%)	Data was being validated	28.6%	N/A
Surgery: Referral to treatment, on completed admitted pathways in Surgery, within 18 weeks (%)	61.7%	60.1%	-1.6%
Medicine: SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator	Level D	Level D	Quarterly reporting so remains as declining until next update
Medicine: Referral to treatment, on completed admitted pathways in Medicine, within 18 weeks (%)	93.3%	90.2%	-2.1%
Outpatients: Patients waiting over 6 weeks for diagnostic test (%)	18.61%	19.1%	+0.49%
ED: Admissions waiting 4-12 hours from the decision to admit (%)	69.7%	70.5%	+0.8%

The information provided in **Table 2** and the challenges that this creates in providing safe and effective healthcare are a consequence of:

- Increased staffing pressures contributing to increased levels of sickness

- Increased attendances within Urgent and Emergency Care.
- Static number of patients with no right to reside as a result of wider system pressures.

The Red Flag data triangulates with what is reported through internal intelligence in relation to incidents, complaints, PALS, and risk.

In April 2022 there were 12 indicators (37.5%) showing improvement. In May 2022 this improved to 17 indicators (53.1%). These are detailed in **Appendix 2**. Red Flag indicators relating to the constitutional standards theme demonstrated the most improvement during this reporting period. This was as a result of improvements in ED Red Flag performance indicators:

- A&E Attendees spending more than 12 hours from Decision to Admit to admission.
- Ambulances remaining at hospital for more than 60 minutes (%.)
- Patients spending less than 4 hours in A&E.
- Patients spending less than 4 hours in majors A&E.

2.2 ED Mock Inspection

2.2.1 Overall Action Plan Compliance

The mock inspection for the Emergency Department (ED) had a total of 90 actions, 13 were identified as urgent. Overall action plan compliance is summarised below in **Table 3** with urgent actions noted in **Table 4.**

Table 3 – ED Action Plan Compliance

CQC Action Plan Compliance			
	April	May	June
Red*	1	1	1
Amber	20	18	15
Green	69	71	74
Overall actions	**90**	**90**	**90**

* This action relates to refurbishment of the CDU sluice. On 5 July 2022 there is an ED reconfiguration paper being presented. A decision will be made regarding capital funding for this work outlined.

Key:

Purple	Action not initiated
Red	Action initiated but risk to achieving completion date
Amber	On track to achieve completion date
Green	Complete but assurance embedded not received
Blue	Complete, assurance evidence embedded received and passed to CBU for monitoring

Outstanding amber action themes relate to:

- Estates
- Flow
- IPC
- Medicines
- Patient Experience, and
- Operational Performance

At the Moving to Outstanding Steering Group on 23 June 2022 the ED Clinical Business Unit (CBU) Manager advised that all actions were on track. Monitoring of the action plan is reported through CBU governance meetings, Care Group meetings and via the Moving to Outstanding Steering Group.

2.2.2 Urgent Actions

Table 4 – ED Urgent Actions

Actions	Update	Target date
Out of date medicines were identified. Processes and procedures to be strengthened for assurance of stock checking.	The Standard Operating Procedure is in draft for final ratification.	14 July 2022
Lanyards need multiple break points to mitigate a strangulation risk.	Procurement are sourcing the lanyards.	14 July 2022
Privacy and dignity for patients cared for outside of cubicles when in an escalated position.	The Standard Operating Procedure Corridor Care is in draft for final ratification.	8 July 2022

2.2.3 Additional Actions

As a result of continued increased patient attendances, additional actions for assurance will be added to the ED action plan relating to:

- Triage Times
- Intentional Rounding
- NEWS2/ Escalation of the deteriorating patients
- Corridor Care

The actions will be reported to the next Moving to Outstanding Steering Group on 21 July 2022.

2.2.4 Regulatory Breaches

During the ED inspection, the 4 regulatory breaches received in 2019 following the CQC's responsive inspection were reviewed and cannot be closed ahead of the next inspection (**Table 5**). Due to current system pressures challenges remain under regulation 12.

Table 5 – Regulatory breaches

Regulation Breached	
12: Safe Care and Treatment	Crowding in the emergency department must be reduced so that patients do not have to wait on trolleys in corridors. Regulation 12(2)(b)
12: Safe Care and Treatment	Patients whose clinical condition is at risk of deteriorating must be rapidly identified and reviewed at suitable intervals. Regulation 12(2)(a)(b)
17: Good governance	Information about the performance of the service is accurate and properly analysed and reviewed by the leadership team. Regulation 17(2)(a)
18: Safe Staffing	There are sufficient numbers of suitably qualified, skilled and experienced doctors and nurses to meet the needs of patients in the Emergency Department. Regulation 18(1)

2.3 Surgery

2.3.1 Overall Action Plan Compliance

Following the inspection, 127 Moving to Outstanding actions and 14 urgent actions (see 2.4.2) were identified. 4 remain outstanding (Table 6). The Moving to Outstanding actions are on track, as confirmed by Lead Nurse for Surgery at the Moving to Outstanding Steering Group on 23 June 2022.

Themes from all the Surgery actions relate to:

- Appraisals
- Equipment
- Estates
- Information Governance
- Infection, Prevention and Control
- Medicines management
- Patient Experience

2.3.2 Urgent Actions

Table 6 – Urgent Actions

Actions	Update	Target date
IV fluid storage in anaesthetic rooms must meet BS 2881 standards – upgrade required	Medicines cabinets have been ordered and will be installed.	30 September 2022
Medicine cupboards on PACU must meet BS 2881 to comply with medicines storage regulations	Medicines cabinets have been ordered and will be installed.	30 September 2022
There must be locked access to maternity theatres	Estates work is underway and is scheduled to complete at the end of July 2022.	31 July 2022

2.4 Maternity

2.4.1 Overall Action Plan Compliance

To enable all actions for maternity reviews to be in one place, maternity now has one overarching action plan. This now includes an action plan to capture the National Maternity Survey and has been developed alongside the Maternity Voice Partnership and Multi-Disciplinary Team. Maternity have 291 actions underway. **Table 7** shows overall compliance across all action plans in Maternity following the compliance review.

Table 7 – Maternity Action Plan Compliance

Source of Action		May	June	May	June	May	June	May	June	May	June
Aubrey Report	23	0	0	2	2	2	2	19	19	0	0
Ockenden Part 1(a)	53	0	0	5	5	8	8	40	40	0	0
Ockenden Part 1(b)	121	0	0	2	2	4	4	115	115	0	0
Mock Inspection	19	0	0	5	12	9	2	5	5	0	0
M2O	32	0	0	4	9	1	3	16	12	11	8

Maternity Survey	43	0	0		41		2	0	0	0	0
Total	291	0	0	18	71	24	21	195	191	11	8
% of actions completed rating		0%	0%	7.26 %	24.4 %	9.68 %	7.20 %	78.63 %	65.60 %	4.43 %	2.80 %

Key:

Purple	Action not initiated
Red	Action initiated but risk to achieving completion date
Amber	On track to achieve completion date
Green	Complete but assurance embedded not received
Blue	Complete, assurance evidence embedded received and passed to CBU for monitoring

Themes for the 32 'Moving to Outstanding' Actions identified relate to:

- Estates
- Information Governance
- Patient Experience.

Monitoring of the action plan continues through CBU governance meetings, Care Group meetings, via the Moving to Outstanding Steering Group and monthly Compliance Team reviews.

2.4.2 Urgent Actions

19 urgent maternity actions were identified at the time of the mock inspection. 5 urgent actions remain outstanding and are denoted below in **Table 8**.

Table 8 – Maternity Urgent Actions

Action	Plan	Lead	Completion by	Evidence
Ensuring two staff undertake swab counts	Case notes audit/electronic audit of 50 records	Lead theatre MW	14 July 2022	Audit report
Improvements in Culture	Introducing Caring for Our Team project (COT Project) Band 7 Staff undertaking leadership development programmes Introduce CBU Triumvirate walk the floor sessions on Monthly basis	Deputy Head of Midwifery	30/09/2022	Pre and post staff survey following COT project CBU Triumvirate walk the floor proformas for 6/12
The service should improve mandatory training compliance in	A trajectory is in place to achieve compliance by the end of July 2022	Director of Midwifery	31/7/2022	Improved compliance evidenced in ESR

line with Trust targets				
The service should improve Safeguarding training compliance in line with Trust targets	The Trust has appointed an additional Safeguarding Midwife. This appointment will continue to support in improving training compliance The service is on trajectory to achieve compliance by September 2022	Director of Midwifery	30/09/2022	Improved compliance evidenced in ESR
To increase the number of completed appraisals across the service	A trajectory is in place to achieve compliance by the end of July 2022	Director of Midwifery	30 November 2022	Improved appraisal compliance on the dashboard

Table 9 compares training and appraisal compliance for Maternity from the time of the inspection (April 2021) compared to May 2022 and June 2022.

Table 9 – Maternity Training and Appraisal Compliance

Area	April 2021	Compliance -May 2022	Compliance - reported June 2022	Trend
Appraisals*	65.77%	57.10%	57.30%	h
Role Specific training	83.02%	88.88%	88.92%	h
Core Skills training	76.56%	84.98%	85.15%	h
Adults Level 2 Safeguarding	60.90%	70.58%	74.52%	h

Appraisal compliance was below Trust targets at the time of the inspection and the Trust's recovery trajectory of 65% for April 2022. A trajectory is in place to achieve compliance by the end of July 2022. This is being overseen by the Director of Midwifery. The appointment of a Safeguarding Midwife will offer additional compliance and training support. The service is on trajectory to achieve compliance by September 2022.

2.5 Outpatients

2.5.1 Urgent Action

Following the mock inspection of Outpatients, one urgent action was identified which was completed at the time of the inspection. This related to staff using clinical treatment rooms as a corridor whilst they were in use.

2.5.2 Moving to Outstanding Initial Actions

At the time of the inspection a further 26 Moving to Outstanding actions were agreed. There are a total of 51 actions to progress the service to a level considered to be CQC outstanding**.**

2.6 Mock inspection programme

In line with the mock inspection schedule, no inspections have taken place in the last month. The Compliance Team have focused on:

- Developing further Moving to Outstanding actions in Surgery and Outpatients to support the services target outstanding practice.
- A compliance review of the Maternity action plan.
- An ED action plan review with the CBU Team and Unplanned Care Triumvirate to prioritise areas for improvement.

Plans are in place as part of the mock inspection programme to undertake unannounced inspections in the following areas:

- Medical Care
- Critical Care
- End of Life Care
- Children and Young People
- Diagnostics
- Gynaecology
- Urgent Care Centre at the Halton Hospital site.

2.7 CQC Enquiries

From 20 May 2022 the Trust has received one new enquiry. This was a request for the Ockenden 2 action plan and NHSE/I report following the Ockenden Insight visit scheduled for 29 July 2022. It has been agreed with the CQC that:

- The Ockenden 2 action plan will be shared once it has been submitted to the Local Maternity and Neonatal System (LMNS) on 30 June 2022.
- The Ockenden Insight visit report will be shared with appropriate assurances once the Trust receive it (expected within a fortnight of the visit on 29 July 2022).

There are no concerns to escalate to this Committee in relation to CQC enquiries.

2.8 CQC engagement meeting

The CQC Engagement meeting was held on 24 May 2022. There were no concerns raised at the meeting. Items discussed included operational capacity and capability including work undertaken with system partners, restoration, risk, governance, patient safety and staff wellbeing. An update was also provided on consultation regarding Breast Screening. Positive feedback was received in relation to the Navajo Merseyside & Cheshire LGBTIQA+ Charter Mark assessment. The next engagement meeting is scheduled on site for 18 July 2022.

2.8.1 Coroner Regulatory 28 Prevention of Future Deaths Reports

The Trust has had no Regulatory 28 Reports issued since 2018.

2.9 Well-led

WHH has commissioned the Good Governance Institute to undertake a 'Well-led' review. It will last for approximately six-eight weeks and is due to commence on 5 July 2022. This will be followed by an internal well-led review for additional assurance.

2.10 Communications

The Communication Plan has three domains and forms part of the Well Led Framework that requires support from the Communications Department and Patient Experience Team:

- The production of patient information
- Compliance with the accessible information standards
- The engagement, participation and involvement of service users, wider stakeholders, and our community in the development of our services.

At the Moving to Outstanding Steering Group the Senior Communications and Involvement Manager confirmed that all actions in the underpinning workstreams for each domain are on track. Actions are also reported into the Patient Experience Sub-Committee.

2.11 Mandatory Training Compliance

Trajectories for Mandatory Training, Role Specific Training, Safeguarding and Appraisal were provided to the Moving to Outstanding Steering Group on 23 June 2022. An overview is shown below in **Table 10**.

Table 10 – Overview of Mandatory Training Compliance

Training	April 2022 position	May 2022 position	Trajectory
Core Skills Training Framework (CSTF)	85.47%	84.63%	85%
Role Specific Training (RST)	91.35%	91.34%	85%
Safeguarding	73.03%	70.15%	77%

* Amber is below trajectory – Green indicates compliant with trajectory

At the Moving to Outstanding Steering Group the Associate Chief People Officer advised that a Mandatory and Role Specific Training Group has been established. This group will target sustained improved training compliance.

2.12 Appraisal Compliance

Table 11 shows appraisal compliance across the Trust comparing April 2022 to May 2022.

Table 11 – Appraisal Compliance

Training	April 2022 position	May 2022 position	Trajectory
Appraisals	61.42%	60.63%	65%

* Amber is below trajectory

There has been a decline in appraisal compliance of 0.79%. The use of 'Check in' conversations as an alternative to full appraisals have been extended until the end of July 2022. Compliance and plans for improvement are being monitored through the Operational People Committee.

2.13 Use of resources

The Use of Resources Assessment is suspended whilst a new framework is developed. Internal work continues to be completed ahead of further direction from NHSE/I. There are no concerns to escalate to this Committee.

2.14 External Reviews, Assessments and Accreditations

2.14.1 Human Tissue Authority (HTA) Inspection

The HTA inspection was undertaken between 11-20 May 2022. The draft report has been received and is going through a factual accuracy process. Upon receipt of the report, one critical shortfall and 8 major shortfalls have been proposed relating to dignity of deceased patients on transfer.

8 major shortfalls have been identified relating to:

- Consent
- A documented system of audit in relation to tissue storage
- Traceability of bodies
- Clear demarcation between different areas within the mortuary.

Assurance has been provided to the HTA regarding the actions the Trust are taking to address the concerns.

2.14.2 Royal College of Paediatrics and Child Health (RCPCH) Peer Review

The draft report has been received from the RCPCH and is being reviewed for factual accuracy. The report describes the service as 'award winning' with a team that displayed 'an extremely positive attitude towards the review'. It noted that 'the team were praised by the parent representatives who described the service ' incredible'. The report highlighted one serious concern related to dietetic provision. This was addressed the day after the visit and the vacancy is out for advert.

2.14.3 Ockenden 1 Insight visit

NHSE/I are undertaking Ockenden 1 Insight review visits to ensure that the Trust's action from the Ockenden part 1 review are becoming embedded. The Ockenden 1 Insight visit is scheduled for 29 July 2022. Plans are in place with weekly meetings to prepare collation of evidence and support staff preparedness for this review visit. Executive oversight is provided at fortnightly Ockenden part 2 meetings.

2.14.4 UKAS inspections

The UK Accreditation Service (UKAS) is inspecting the Trust's laboratories at Warrington on:

- 26 - 27 July 2022
- 2 - 3 August 2022
- 9 - 10 August 2022
- 16 - 17 August 2022

Assurance can be offered that actions are on track for the inspection. The inspection is being led by the Pathology Quality Manager with support from the Associate Director of Clinical Support Services. Fortnightly meetings are in place for oversight of progress.

3 ASSURANCE COMMITTEE

This paper will continue to be provided on a bi-monthly basis to the Quality Assurance Committee.

4 RECOMMENDATIONS

The Board of Directors are asked to note the contents of this paper.

Appendix one

Indicator theme	Actions taken to target improvement
Sickness	• Reasons for absence identified to inform actions required • Specific support offered from HR for areas with high sickness/low return to work figures • Improved health and well-being offering
Turnover	• Reasons for leaving identified to target actions required • Agile working group established to support work-life balance • Improved health and wellbeing offering
Constitutional Targets	• Working with partners to reduce right to reside by 50% • Daily system meetings continue focused on increasing capacity in care homes, consideration of out of area beds, block booking of beds and revision of admission criteria for a care home • 'Home for' campaigns e.g. Home for Jubilee • Emergency Care Improvement Support Team (ECIST) work on workforce remodelling used to mirror activity with capacity, demand, and productivity • Additional bed capacity continues to be utilised at the 'green' Halton site for medically optimised patients • Use of the respiratory virtual ward to support early discharge planning and admission avoidance • Development of a virtual frailty ward • ED plaza • Elective theatre capacity restored
Effective Care Provision	• Peer review • Rehabilitation consultant recruited • Repatriation rate continues to improve to positively impact SSNAP • Recruitment ongoing for substantive Stroke Consultant

Appendix two – Indicators showing improvement

Indicator	Performance reported April 2022	Performance reported May 2022	Variance
Trust wide: Ratio of occupied beds to nursing staff	8.4 Care hours per patient day (CHPPD)	8.5 CHPPD	+ 0.1
Trust wide: Ratio of ward manager nurses to senior and staff nurses	Vacancies: HCAs – 105.97 WTE RGNs – 119.9 WTE	Vacancies: HCAs – 79.08 WTE RGNs – 100.7 WTE	Vacancies: HCAs -26.89 WTE RGNs –19.2 WTE
Trust wide: Turnover rate for other clinical staff (%)	19.26%	17.38%	- 1.88%
ED: A&E Attendees spending more than 12 hours from decision to admit to admission	284 May 22	227	-57
ED: Ambulances remaining at hospital for more than 60 minutes (%)	8.8%	3.5%	+ 5.3%
ED: Patients spending less than 4 hours in (any type of) A&E (%)	69.7%	70.5%	+ 0.8
ED: Patients spending less than 4 hours in majors A&E (%)	58.5%	60.5%	+2.0%
Medicine: Emergency readmissions: Urinary tract infections (%)	95.7%	84.2%	-11.5%
Medicine: In-hospital mortality: Fractured neck of femur (hip)	4 deaths (Oct - Dec 21)	3 deaths (Jan – Mar 22)	- 1 death
Medicine: In-hospital mortality: Urinary tract infections	20 deaths (Feb 21 – Jan 22)	17 deaths (Apr 21 – Mar 22)	- 3 deaths
Medicine: In-hospital mortality: Acute bronchitis	2 deaths (Feb 21 – Jan 22)	2 deaths (Apr 21 – Mar 22)	- 1 death
Surgery: Crude proportion of patients having perioperative medical assessment (%)	92%	100%	+ 8%
Surgery: Crude overall hospital length of stay	16.9 days	14.9 days	-2 days
Surgery: Crude proportion of patients having surgery on the day or day after admission (%)	5.5%	30%	+24.5%
Surgery: Patients consented to have personal details included in the National Joint Registry (NJR)	67%	88%	+21%
Cancer: First treatment in 62 days of urgent GP/dentist referral (%)	77.1%	79.6%	+2.5%
Outpatients: Referral to treatment, on incomplete pathways, within 18 weeks (%)	66.49%	68.4%	+1.91%

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/07/90 i**	
SUBJECT:	**Quarter 2 Perinatal Mortality Review Report**	
DATE OF MEETING:	27th July 2022	
AUTHOR(S):	Catherine Owens, Director of Midwifery/Associate Chief Nurse	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	N/A	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The NHS Long Term Plan is to achieve a 50% reduction in stillbirths and neonatal deaths by 2025. The National Perinatal Review Tool (PMRT) has been developed to standardise the reviews of still births and neonatal deaths across England, Scotland and Wales. NHS Resolution (NHSR) have incorporated the use of the National Perinatal Mortality Review Tool into Safety Action One of the Maternity Incentive Scheme (MIS) (Year 4) in September 2021 to ensure Trust Boards receive quarterly perinatal mortality review reports. MIS recommends quarterly reporting of PMRT reports. Quarter 2 (Q2.) PMRT report was not reported to QAC previously. This was an administrative oversight of the CBU due to change in clinical leadership. No external reporting has been breached. Quarter 3 and Quarter 4 PMRT reports have incorporated Quarter 2 data. This paper presents Warrington and Halton Teaching Hospitals (WHH) Q2. PMRT report for the reporting period covering 01/07/21 – 30/02/22. In Q2. WHH reported two babies still born to Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE): 1 baby stillborn at 22 weeks gestation. MBRRACE advised the use of the perinatal mortality review tool is not supported at this gestation. 1 baby stillborn at 28 Weeks and 3 days gestation. 0 Neonatal Deaths reported. WHH stillbirth rate for Q2 2021/22 was 1.41 per 1000 births. WHH Mean rate is 3.01/1000 births. MBRRACE-UK national rate is3.51/1000 births.	

	WHH annual stillbirth rate for 01/01/21-31/12/21 is 2.30 per 1000 births. Please note this is not a national reporting timeline and included to illustrate the impact of small numbers in short reporting timelines. PMRT reviews are all graded as either A B C or D as per care undertaken and outcome incurred. 1 baby's care was reported as C in which care may have changed the outcome for the baby. This birth was reported to The Strategic Executive Information System (STEIS) and a full investigation completed using WHH Serious Incident Framework. All learning has been shared via Women's and Children's Governance pathway. 1 action remains outstanding in relation to providing feedback/learning to a midwife; the midwife is currently on long term sick. The PMRT action plan is monitored quarterly at Women's and Children's Governance Committee and QAC as per MIS Year 4 Safety Action 1 recommendation.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note	Decision
RECOMMENDATION:	The Trust Board is asked to XXXXX			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Quarter 2 Perinatal Mortality Review Report	AGENDA REF:	BM/22/07/90 i

1. BACKGROUND/CONTEXT

The NHS Long Term Plan is to achieve a 50% reduction in stillbirths and neonatal deaths by 2025.

The Mothers and Babies Reducing Risk through Audits and Confidential Enquires (MBRRACE) -UK confidential enquiries reported 60-80% of term perinatal deaths might have been prevented and recommends Trusts should undertake robust reviews and develop lessons learned to reduce the rate of stillbirth.

NHS Resolution have incorporated the national Perinatal Mortality Review Tool into Safety Action One of the Maternity Incentive Scheme Year 4 standards and recommended each maternity service audits all babies born still born and neonatal deaths to its Trust Boards using a PMRT reporting template. The audit and reports must be presented quarterly.

Please note Q2 should have been presented to Quality Assurance Committee previously however this has been missed due to change in leadership and oversight when new in post. During the writing of the PMRT Annual report the omission was noted. The Q2. PMRT report was reported to MBRRACE within national reporting timelines. All data and learning gained in Q2 was incorporated in to Quarter 3 and Quarter 4 PMRT reports which have been presented to QAC and Trust Board in accordance with Maternity Incentive Scheme recommendations.

This report presents WHH Quarter 2 PMRT audit using the new Cheshire and Mersey PMRT reporting template 2021/2022 and highlights good practice and lessons learned during the mortality reviews. The Quarter 2 period covers the reporting period from 01/07/22 to 30/09/2022.

Definitions

- **Perinatal mortality** refers to the number of stillbirths ad and early neonatal deaths in the first week of life.
- **Late Fetal Loss** is when a baby is born between 22+0- and 23+6 weeks' gestation showing no signs of life.
- **Stillbirth** is when a baby is born showing no signs of life after 24+0 weeks of pregnancy.
- **Early Neonatal death** occurs when a baby is born after 20+0 weeks gestation or weighs 400grams or more and lives but dies within 7 days of being born.
- **Neonatal Mortality Rate** refers to the number of babies who have died within the first 28 days of life.
- **Perinatal Mortality Review Tool (PMRT)** is a national standardised approach to systematically review circumstances and care leading up to and surrounding each stillbirth and neonatal death. The review should incorporate a multidisciplinary approach which includes communication with parents on their experience of care provided and any questions they may have. Following the review, a grading of care is provided by the multidisciplinary review team.

2. KEY ELEMENTS

The Perinatal Review Tool has been developed to standardise the reviews of still births and neonatal deaths across England, Scotland and Wales. The full Cheshire and Mersey PMRT report can be reviewed in Appendix 1 of this paper.

This paper has been written in retrospect and has extracted the key findings of the report for your information and noting. The report has been completed using the new Cheshire and Mersey PMRT template which was introduced in January 2022 and presents Warrington and Halton Teaching Hospitals (WHH) NHS Foundation Trust Quarter 2 PMRT report for the period covering 01/07/21 – 30/09/21

During this Q2. reporting period 2 babies were reported to Mother and Babies: Reporting Risk through Audit and Confidential Enquires (MBRRACE UK):

- 2 babies were stillborn

2.1 Surveillance findings for the 4 cases in association of increased risk factors

- **Gestation**
  1 baby aged 28+3 weeks gestation
  1 baby aged 22 weeks gestation (MBRRACE recommended not to support the use of the PMRT process due to extreme premature gestation)

- **Ethnicity**

  Both women were identified as white ethnicity

- **Body Mass Index (BMI)**
  1 woman had a healthy BMI at booking of 25Kg/M²
  1 woman had no antenatal care due to being unaware of the pregnancy until the baby was born. No BMI was booking was calculated.

- **Carbon Monoxide (CO) levels**

  One woman was reported as a smoker and advised the Midwife she was trying to stop. CO Monitoring was suspended during COVID thus not recorded.

  The second woman received no antenatal care provided as unaware of the pregnancy until birth. Smoking status not recorded.

- **Place of birth**

  All babies were born at Warrington and Halton Teaching Hospitals (WHH)

2.2 Summary of completed PMRT reviews for Quarter 2:

Table 1: Summary of WHH Stillbirth

Stillbirths and late fetal losses 01/07/2021 – 30/09/2021		
Number of stillbirths and late fetal losses reported to MBRRACE	Number not suitable for PMRT Review	Grading of care: Number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby.
2	**1**	**1**

Table 2: Summary of Neonatal Deaths

Neonatal and post neonatal deaths 01/07/2021– 30/09/2022
Number of stillbirths and late fetal losses reported to MBRRACE
0

2.3 Q2: WHH Stillbirth Findings

Situation	**Baby found to be stillborn at 28 weeks and 3 days gestation**	**Learning**
Background	Second pregnancy, 1 previous liveborn Aged 21 years, BMI 25 (normal) Smoked 10 cigarettes per day Booked with Warrington & Halton Hospital, lived out of area (OOA)	
Actions	Telephone Booking undertaken as recommended during COVID	
	Omitted to refer to smoking cessation at booking	MW was previous smoking cessation midwife and gave verbal advice with plan to refer at next visit if had not stopped smoking
	Care given across 2 maternity providers. Lack of coordination & communication of ante natal appointments	25-week appointment recommended however no evidence of appointment being made

		Missed opportunities to make smoking cessation referral
	Women declined smoking cessation referral at 18 weeks at WHH appointment	Omitted to follow opt out referral pathway where referral would have been made
	WHH MW did not follow guidance for reduced fetal movement when attending triage. Omitted to measure fundal height, fetal monitoring and refer to obstetrician	Omitted to refer to Doctor for review and to request scan
Recommendations	STEIS Reported due to harm related to omission to follow Reduce Fetal Movement pathway	WHH Serious Incident framework followed. Duty of Candour completed, and governance process followed. Learning shared. 1 action outstanding in relation to personalised feedback to a staff member on long term leave.
	Face to Face education of staff re smoking cessation pathway and link to Saving Babies Lives Care bundle	Face to face training suspended during COVID. Online learning has been introduced following case as interim. Review of smoking cessation team being undertaken.
	Individual feedback and reflection facilitated with midwife in relation to Reduced Fetal Movement pathway	Individual reflection undertaken with midwife and Professional Midwifery advocate. Since this incident Birmingham Systems of Obstetric Triage (BSOTS) has been implemented which utilises a proforma that supports staff to assess clinical need effectively.

2.5 Q2 WHH Stillbirth rate

- WHH Q2 stillbirth rate for 2021/22 is 1.41 per 1000 births.
- WHH Mean stillbirth rate is 3.01/1000 births which is below the MBRRACE-UK national stillbirth rate which is 3.51/1000 births
- WHH annual stillbirth rate for 01/01/21-31/12/21 is 2.30 per 1000 births. Please note this is not a national reporting schedule and has been added to contextualise the impact small numbers can have on short reporting timeline seen per quarter

2.6 Q2 Neonatal Mortality rate

The Neonatal Mortality Rate refers to the number of babies that have died following their birth and up to 28 days

- WHH Neonatal mortality rate during Quarter 2 2021/22 was 0.0 per 1000 live births.
- WHH mean rate is 0.4/1000 live births which is below the MBRRACE-UK national rate of 1.64/1000 live births

Quarter 2 North West Operational Delivery Network Neonatal Mortality dashboard

NWNODN Dashboard - Locality Unit

Cheshire & Mersyside

Measure	Location	202021_Q4	202122_Q1	202122_Q2	202122_Q3	Mean	NWNODN Target	
MORTALITY PER 1,000 LIVE BIRTHS	NWNODN	1.9	1.0	1.7	2.1	1.7	NA	1.6
	Cheshire & Merseyside	1.9	0.7	1.3	2.2	1.5	NA	1.9
	Arrowe Park, Wirral	1.5	1.3	0.0	2.6	1.3	NA	1.4
	Countess of Chester	0.0	0.0	1.6	0.0	0.4	NA	0.4
	Leighton	0.0	1.3	1.2	0.0	0.6	NA	0.3
	Liverpool Womens Hospital	4.5	0.5	3.6	5.3	3.4	NA	4.9
	Macclesfield District General					0.0	NA	0.0
	Ormskirk	2.1	0.0	0.0	0.0	0.4	NA	0.5
	Warrington	0.0	1.6	0.0	0.0	0.4	NA	0.4
	Whiston	1.1	0.0	0.0	2.0	0.8	NA	0.5

2.7 PMRT Grading of Care

Each PMRT review panel consists of senior obstetric, midwifery, bereavement, and governance representation from WHH and external peer review from another maternity providers within Cheshire and Mersey Local Maternity and Neonatal System.

The PMRT review concludes with each panel member reporting if in their professional opinion the care given up to the point where the baby was confirmed as having died and or care provided following the birth of the baby could have made a difference and is classified as follows:

A No issues with the care provided

B Care issues identified which would have made no difference to the outcome of the baby

C Care issues identified which may have made a difference to the outcome of the baby

D Care issues identified which is likely to have made a difference to the outcome of the baby

Table 3: WHH Q2 Grading of Care of completed PMRT reports:

PMRT grading	Care provided to the mother up to the point that the baby was confirmed as having died	Care provided to the mother following confirmation of the death of her baby
PMRT grade A **No issues with care identified up to the point that the baby was confirmed as having died**		2 cases
PMRT grade B **Care issues which would have made no difference to the outcome for the baby**		
PMRT grade C **Care issues which may have made a difference to the outcome for the baby**	1 case	-
PMRT grade D **Care issues which were likely to have made a difference to the outcome for the baby**	-	-
Not Graded	-	-
Total cases	1 (+ unable to classify 1 baby)	2

The grade C case was STEIS reported. Indication discussed earlier in the report.

Table 4 Q2 PMRT Action Plan

ID	Lead	Completed Date	Recommendation	Progress update	RAG Rating
10601	GS	09/07/2021	Report to PMRT / STEIS	completed	
10598	CB	18/08/2021	Staff reminder to be shared that a smoking cessation referral must be completed for patients smoking at booking and the patient can later opt out	completed	
10599	CB	18/08/2022	Staff reminder to be shared; CTG from 26 weeks any risk factors i.e., smoking ultrasound scan to be booked.	completed	
10602	LD	18/08/2021	Matron and smoking cessation midwife to discuss sharing information / learning around ensuring referrals are completed	completed	
10600	AGJ	30/7/22	Matron to feedback results of the Rapid Review to individual midwife and request a statement	Awaiting return of staff member from long term leave	

2.80 Summary

WHH Q2 PMRT Report has been undertaken using the new Cheshire and Mersey PMRT template and reported 2 babies to MBRRACE during the Q2. reporting period of 1/7/21 to 30/09/21.

1 baby did not meet the PMRT criteria due to premature gestation.

No neonatal deaths were reported.

WHH Stillbirth rate for Q2 was 1.41 per 1000 births. National MBRRACE Stillbirth rate is 3.51 per 1000 births.

WHH Neonatal Mortality rate for Q2 is 0.0 per 1000 births. MBRRACE National Neonatal Mortality Rate is 1.64 per 000 births.

The grading of care classified 1 baby as C which identified care issues which may have made a difference to the outcome of the baby. In view of this the birth was STEIS reported and a full investigation completed using WHH Serious Incident Framework. Duty of Candour was completed.

Learning has been shared through Women's and Children's governance processes. I action remains outstanding in relation to individual feedback being given to a staff member who is on long term leave.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

4. IMPACT ON QPS?

5. MEASUREMENTS/EVALUATIONS

6. TRAJECTORIES/OBJECTIVES AGREED

7. MONITORING/REPORTING ROUTES

8. TIMELINES

9. ASSURANCE COMMITTEE

10. RECOMMENDATIONS

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/07/90 ii**	
SUBJECT:	**Maternity Incentive Scheme Year 4: Safety Action 5 Midwifery Staffing and Birth Rate Plus report**	
DATE OF MEETING:	27th July 2022	
AUTHOR(S):	Catherine Owens, Director of Midwifery/Associate Chief Nurse	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x x x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper has been presented at Quality Assurance Committee (QAC) on 5th July and was noted for information. Maternity Incentive Scheme (MIS) Year 4 Safety Action 5 recommendation is that the Trust Board must provide evidence in published Board, minutes of the funded establishment being compliant with Birthrate Plus (BR+) and Ockenden. This paper updates the Trust Board of the maternity staffing position in relation to Birth Rate Plus (BR+) report received in February 2022 and current staffing review. BR+ findings have been shared previously in the Maternity update paper at Trust Board in May 2022. Warrington and Halton Teaching Hospital (WHH) BR+ midwifery ratio is 1:24 which in line with current recommendations.	

	Since the BR+ report was received WHH has experienced increased vacancies which mirrors the national midwifery staffing portfolio. Current staffing vacancy is 15.8% of which most vacancies have been appointed to and are due to commence in September 2022. The current BR+ acuity tool is being updated to include an 'app based' programme that captures all birthing environments and inpatient areas. Birthing Suite staff have completed their BR+ training in July; Women's and Children's materntiy unit is now awaiting imstallation of the tool. Staffing levels are reviewed daily by the Women's and Children's Senior Management Team utilising the Maternity Bleep Holder Standard Operating Procedure and where acuity levels are high are escalated via the North West Escalation and Divert Policy through the Senior Manager on Call and Executive on call.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to note the information in this paper. As per MIS Year 4 recommendations.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.			
	Date of meeting	5th July 2022		
	Summary of Outcome	Noted for information		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	**Maternity Incentive Scheme Year 4: Safety Action 5 Midwifery Staffing and Birth Rate Plus report**	**AGENDA REF:**	**BM/22/07/90 ii**

1. BACKGROUND/CONTEXT

Maternity Incentive Scheme Year 4, Safety Action 5 recommends maternity providers can demonstrate an effective system of midwifery workforce planning to the required standard. New specifications released by National Health Service Resolution (NHSR) MIS in May 2022 stipulate the Trust Board must provide evidence in published Board Minutes of the funded establishment being compliant with BR+ and Ockenden.

Birthrate Plus (BR+) is a nationally recognised and systematic framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988.

The paper will highlight Warrington and Halton (WHH) BR+ assessment and results which are based on three months case mix data obtained for the months of September – November 2020 and current staffing position.

The final report was received in February 2022 of which the initial findings were shared with Quality Assurance Committee in April 2022. In May 2022 MIS released updated guidance in relation to Safety Action 5. This paper will provide the Quality Assurance Committee (QAC) of the current maternity staffing position and action plan.

Maternity staffing is reviewed daily within the Women's and Children's Clinical Business Unit (W&C CBU) and monitored quarterly at the W&C CBU Governance meeting. A high-level briefing Staffing Paper/maternity update is also provided to Workforce planning bi annually.

2. KEY ELEMENTS

2.1 Summary of Warrington and Halton Birth Rate Plus Report

Birthrate Plus (BR+) has been used to assess and calculate the midwifery workforce in maternity units for 34 years and is recommended by the Royal College of Midwives as a systematic tool to support workforce calculations and safe staffing levels.

The methodology remains responsive to changes in government policies on maternity services and clinical practices. BR+ is the most widely used system for classifying women and babies according to their needs and using clinical outcome data to calculate the numbers of midwives required to provide intrapartum and postpartum care.

The results are based on three months case mix data obtained for the months of

September – November 2021. An allowance of 23% uplift for annual, sick and study leave, and 12.5% community travel are included in the staffing figures.

Annual Activity was based on the Financial Year 2020/2021 and total births of 2609, allocated as below:

- 2285 Birth Suite births
- 264 The Nest Birth Centre
- 60 births at Home/Born Before Arrival (BBA)

The BR+ staffing is based on the activity and methodology rather than on where women may be seen and or which midwives provide the care. Time is included for Band 7 Coordinators, Ward and Department Managers and Team Leaders to cover the day-to-day management and coordination in all areas.

The total clinical establishment of 106.09 Whole Time Equivalents (WTE) excludes the non-clinical midwifery roles needed to provide maternity services and include: Director of Midwifery, Deputy Head of Midwifery & Matron/managers with additional hours for team leaders to participate in strategic planning & wider Trust business. Additional time for specialist midwives to undertake audits, training of staff is also included.

a. Summary of Findings

Based on 2020/21 activity and a 23% uplift, the clinical midwifery workforce total, recommended for Warrington & Halton Teaching Hospitals NHS Foundation Trust is 106.09 Whole Time Equivalent (WTE), of this 95.48 WTE could be Registered Midwives bands 5 -7 and 10.61 WTE MSWs providing postnatal care (on the ward/community) if a 90/10% skill mix is applied.

Note: The recommended establishment is based on a 'traditional' way of working a hospital and community shift-based model with an on-call service and does not incorporate Continuity of Carer (COC) caseload teams.

Since the BR+ report was finalised WHH has rolled out 7 Continuity of Carer teams which now offers 100% of women booked at WHH to be cared for on a continuity model. Continuity of Carer Model is recommended as part of Better Births and the National Maternity Transformation Programme.

Table 1: WHH Staffing Calculation

Birthrate Plus® calculation of staff compared to current funded establishment inclusive 23% uplift

WARRINGTON & HALTON NHS TRUST	RMs	MSWs	Bands 3 - 7
Current Total Clinical	100.35	9.49	112.38
Contribution from Specialist MWs	2.54		
Total Current Funded	**102.89**	**9.49**	**112.38**
BR+ Clinical wte			**106.09**
Skill Mix Adjustment (90/10)	95.48	10.61	
Clinical Variance +/-	7.41	-1.12	**6.29**
	Birthrate Plus	Current	**Variance**
Additional Specialist and Management wte	10.61	9.84	**-0.77**
TOTAL CLINICAL, SPECIALIST & MANAGEMENT WTE	**116.70**	**122.22**	**5.52**

As noted above BR+ does not calculate staffing establishment when providing of a continuity of carer model.

2.3 Birth Rate Plus Ratio

The BR+ ratio has reduced the staffing ratios in the last 5 years due to the increased number of women with complex pregnancies and social risk factors. National Birth Rate ratio is recommended at 1:24 based on the number of midwives required against the number of births at a maternity provider.

Warrington & Halton Teaching Hospitals NHS Foundation Trust Ratios:

Birthing Suite births (all hospital inpatient & outpatient care)	31.3 births to 1 wte
The Nest' Birth Centre births	47.9 births to 1 wte
All Hospital Births (DS & BC)	32.4 births to 1 wte
Home births	34.2 births to 1 wte
Community care (Ante & Postnatal)	98.0 cases to 1 wte
Overall ratio for all births	**24.6 births to 1 wte**

2.4 Ockenden

Additional roles and planned activity have been recruited to and funding ring fence time to enable roles to undertake governance activities in relation to the findings within Ockenden Part one report for example lead midwife for fetal surveillance. Additional funding and spending are monitored via Cheshire and Mersey Local Maternity and Neonatal System.

Ockenden Part Two report released in March 2022 has recommended a review of Birth Rate Plus tool to calculate midwifery workforce due the variances identified across England.

Cheshire and Mersey Local Maternity and Neonatal System (C&M LMNS) are currently supporting providers to implement the Birth Rate Plus Acuity Tool to support providers to assess acuity on a 4 hourly basis. The tool is app based and enables wider oversight of acuity across Cheshire and Mersey and ensures each provider is measuring acuity using the same tool. WHH is on track for the current app to be upgraded in July 2022. This will measure acuity across all inpatient areas and birthing environments.

2.5 WHH current staffing position

A national midwifery staffing reduction within the maternity workforce has been predicted for many years. Within the next 5 years it is anticipated 50 % of the midwifery workforce will have retired.

Within the last 6 months we have had an increased number of midwives leave WHH. A deep dive review of the current staffing levels has been undertaken by the Deputy Head of Midwifery who explored:

- Impact of vacancies
- Impact of sickness
- Retention of staff
- Other factors affecting staffing
- Mandatory training requirements

and identified the following findings:

- Significant vacancy rate of 15. 3 % (most of these positions have been filled and will commence post in September/not yet commenced employment)
- Above target rates of sickness and absence
- Above target turnover rate of 32.1% (Trust trajectory is 13%)
- Impact of maternity leave and staff with health restrictions are significant (9.24 WTE staff and 16 Ward/intrapartum shifts per week)
- Maintaining mandatory training requirements need to be reflected in our staffing model. Current mandatory training requirement per midwife is calculated over a 3-year programme:

	Hours per midwife	Days per midwife	FTE
Mandatory Hours/Days per annum	53.5	6.6	1.43
In addition -Hours/Days required for once only training	8	1	0.21
In addition- Hours/Days required every two years	4	0.5	0.11
In addition- Hours/Days required every three years	2	2	0.05
Day = 8 hours (Excludes any training via e-learning of 1 hour or less)			

2.6 Current permanent maternity vacancy rate is 15.3%, equating to 21.17 WTE

22.23 WTE staff have left WHH, 19.12 WTE have joined.

Turnover rate for permanent registered staff May21-Apr 22 was 32.1% against a Trust target of 13%.

Exit interviews identified reason for leaving included retirement, promotion, moving closer to home and ill health.

Most posts are recruited to, but new staff will not commence until September/ October. Recruitment to vacancies remains ongoing but it is clear this is having an impact of staffing levels and need to make measures to fill staffing gaps.

Staffing is reviewed daily and measures taken to maintain safe staffing levels adopted. Where staffing levels are unsafe and or acuity is high the North West Escalation and Divert Policy is activated and escalated through the senior and or executive on call as appropriate. All maternity diverts are Strategic Executive Investigation System (STEIS) reported and investigated using the Serious Incident Framework.

Current absence/sickness rate is 11.31% (of which 6.02% is long term and 4.63% is short term). Long term sickness themes are in relation to bereavement, long term medical conditions, mental health and following injury.

WHH staffing position is not isolated to WHH. There is a national midwifery staffing challenge which is being addressed nationally via increasing the number of student midwife training places, international recruitment programme and different routines to becoming a midwife for example the introduction of apprentice programmes. WHH has the largest number of student midwives in Cheshire and Mersey to increase the number of recruits in the next 3 years.

2.7 Measures taken to assure safe staffing include continuing to:

- Adopt measures to keep staffing levels safe and include:
  - Daily staffing review.
  - Utilising Maternity Bleep Holder Standard Operating Procedure.
  - Releasing shifts via National Health Service Professionals (NHSP)to fill gaps.
  - Follow North West Escalation and Divert Policy to escalate concerns through Senior Manager of Call and Executive team.
- Upgrade current Birth Rate Plus App to help manage and monitor acuity across Cheshire and Mersey. The new upgrade will capture all birthing and inpatient areas.
- Manage sickness and well-being reviews to expediate return to the work place.
- Re mobilising staff from one clinical area to another as indicated by clinical need.
- Retention Midwife recruited to support existing staff in clinical practice including newly qualified midwives and aid attrition of midwives.
- Pursuing International Recruits in cohort 2 of National midwifery recruitment.
- Specialist midwives and ward managers to be mobilised in to the clinical numbers.
- Study leave paused when unable to fill shifts.
- Last option is to postpone training on an individual basis. This is authorised by the senior leadership team and monitored via W&C CBU governance via quarterly reports and monthly exception reports.
- Year 3 Student midwives to be offered NHSP shifts to support clinical activity.

Maternity staffing levels is monitored via Women's and Children's Governance Meeting quarterly and by exception monthly if concerns identified. Maternity safe staffing is also monitored at Trust Board via the bi annually safe staffing report.

2.8 Summary

Maternity Incentive Scheme Year 4, Safety Action 5 recommends maternity providers can demonstrate an effective system of midwifery workforce planning to the required standard. New specifications released by National Health Service Resolution (NHSR) MIS in May 2022 stipulate the Trust Board must provide evidence in published Board Minutes of the funded establishment being compliant with BR+ and Ockenden.

WHH undertook a BR+ assessment for the 3-month period of September to November 2021 and received its Report in February 2022.

BR+ assessment reported WHH BR+ birth staffing ratio is 1:24 which is in line with the national recommended midwifery establishmen.t

Since the report was finalised in February 2022 WHH has experienced increase midwifery turnover and vacancy rate; this mirrors the national midwifery staffing profile.

Currently the Midwifery vacancy rate is 15.3%, equating to 21.17 WTE of which 18.3% is at Band 5 and 6. The majority have been appointed to and are due to commence in September 2022.

WHH is also pursuing international midwifery recruits to increase recruitment and succession planning.

The Trust follows the North West Escalation and Divert Policy to escalate concerns and manage high acuity internally and in the region. WHH is updating its BR+ acuity tool . Midwifery staff have received training in July 2022 and we are now awaiting installation of the app which will capture all birthing and inpatient areas.

Staffing levels are monitored daily by the senior management team and W&C CBU Governance meetings and bi annual via Safe Staffing reports to the Trust Board.

3. MONITORING/REPORTING ROUTES

Materntiy staffing is monitored at Women's and Children's governance meeting and Quality Assurance Committee as part of MIS Year 4 review.

4. RECOMMENDATIONS

The Trust Board is asked to note the findings of this report as per MIS Year 4 Safety Action 5 recommendation that the Trust Board must provide evidence in published Board Minutes of the funded establishment being compliant with BR+ and Ockenden.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/07/90 iii**	
SUBJECT:	**Deep Dive Materntiy Governance Assurance Paper**	
DATE OF MEETING:	27th July 2022	
AUTHOR(S):	Catherine Owens, Director of Midwifery/Associate Chief Nurse	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	N/A	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The information in this paper was presented to Quality Assurance Committee on 7th June 2022 and noted for information. The National Health Service Long Term Plan is to achieve a 50% reduction in stillbirths, maternal mortality and, neonatal mortality and serious brain injry by 2025. Like wise Better Births (2016, Materntiy Incentive Scheme Year 4 (2022), Ockenden Part 1 (2020) and Ockenden Part Two (2022) have identified key actions and recommendations to improve the immediate and continuous safety of materntiy and neonatal services while also improving the experiences of women and their families. Subsequently maternity services have been in the national spotlight for many years and with this brings the scruitiny of multiple governance processes at local, regional an national platforms to gain the required oversight and assurance. This paper will update the Trust Board of the current Governance assurance structures within Warringtn and Halton Teaching Hospitals (WHH), Cheshire and Mersey Local Maternity and Neonatal Services (LMNS) and North West Integrated Care Systems and Boards.	

PURPOSE: *(please select as appropriate)*	Information	Approval	To note	Decision
			x	
RECOMMENDATION:	The Trust Board is asked to note for information			

PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	
	Date of meeting	7th June 2022
	Summary of Outcome	Noted for information
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Deep Dive Materntiy Governence Assurance Processes	AGENDA REF:	BM/22/07/90 iii

1. BACKGROUND/CONTEXT

Better Births Report, National Health Service Resolution (NHSR) Materntiy Incentive Scheme (MIS), Kirkup and Ockenden Reports have all identified immediate actions and recommendations upon which to improve the safety of matertniy and neonatal services. Each report has shared the learning from service users, outcome data and external investgigations.

Good governance is paramount to provide local, regional and national assurance that the National Maternity Transformation Programme and safety agenda is embedded within each materntiy provider and Trust. Materntiy and neonatal services are accountable and must evidence safe practices and services and continue to improve the outcomes and experiences of women and their families.

The governance of materntiy and neonatal services are complex. Combined with the new introduction of Integrated Care Systems, navigation of the governance structures is challenging. This paper will update the Trust Board of the local regional and national governance assurance structures.

2. KEY ELEMENTS

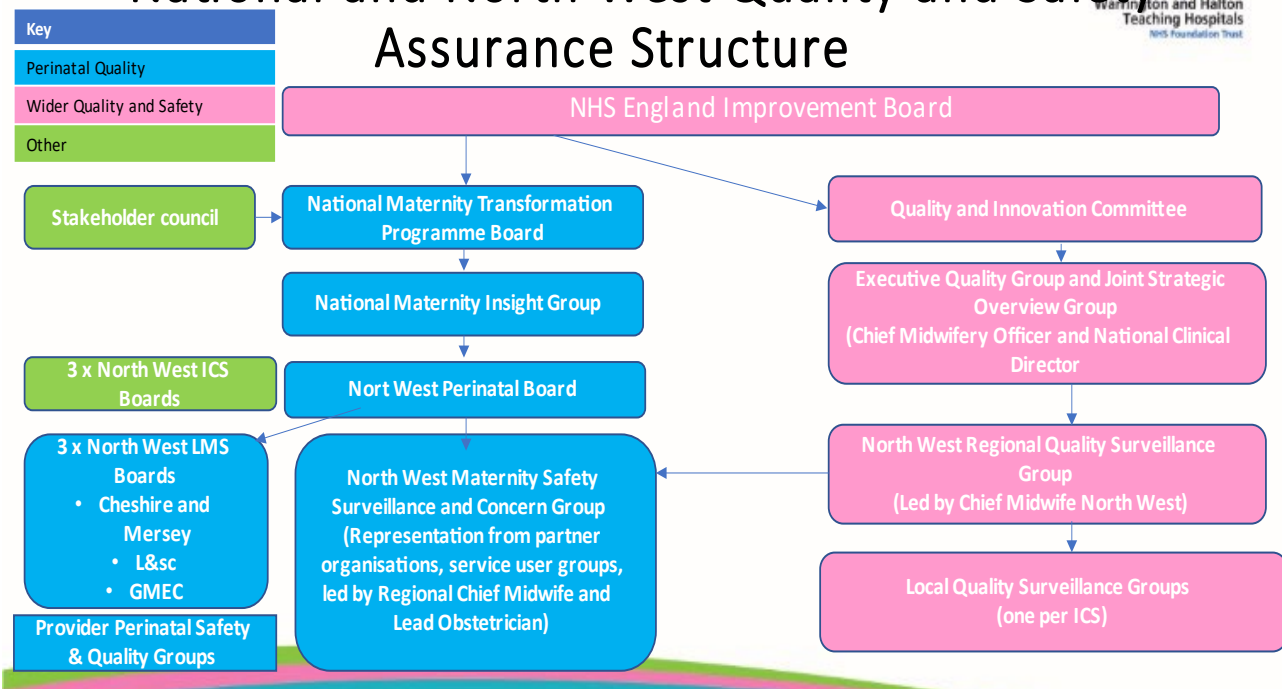
Background

- Structure of maternity assurance reporting is complex
- Multiple reporting requirements

National | **Regional** | **System: Cheshire & Mersey** | **Local WHH**

- National reporting: part of Maternity Transformation Programme
- Regional reporting: part of Local Maternity and Neonatal System (LMNS)
- System: Cheshire & Mersey Local reporting: WHH and Clinical Commissioning Group

National and North West Quality and Safety Assurance Structure



National: Maternity Transformation Programme (MTP)

- MTP Board will drive implementation of 'better births' part of National Maternity Review (2016)
- Achieve the vision set out in Better Births: bringing together a wide range of organisations to lead and deliver across 10 work streams
- Local Maternity Systems, will plan the design and delivery of services. Range of data for inclusion:
- National commissioned reviews:
    - Ockenden
    - Morecambe Bay

Investigation Process	Purpose
Healthcare Safety Investigation Branch (HSIB)	Independent investigations
Perinatal Mortality Review Tool	Standardised objective review with external representation

Cheshire & Mersey Local Maternity Neonatal Structure (LMNS)

LMNS Assurance Board

Quality Safety Surveillance Group (QSSG)

- Serious Incident Panel
- Ockenden Assurance Group
- C&M Heads of Midwifery
- Women's Health and Maternity Programme (WHaM) O&G Operational Group
- Still Birth Safety Improvement Group
- PMRT
- Gold Command Staffing Safety Improvement Group

Key Principles: Role of Cheshire & Mersey LMNS

- LMNS part of Perinatal Quality **Surveillance** Model (QSM)
- Part of Maternity Transformation Programme
- WHH to submit quarterly report

  - **Principle 1:** Strengthening Trust Board oversight of perinatal clinical quality
  - **Principle 2:** LMNS and ICS role in perinatal clinical quality oversight
  - **Principle 3:** Perinatal clinical quality routinely reviewed at regional level committee
  - **Principle 4:** National governance aligned to reflect the QSM
  - **Principle 5:** To support local, regional and national decision making to optimise assurance

Cheshire and Merseyside LMNS Reporting Requirements

Outlier or 'spike' identified by dashboard or during internal processes

Check source data for accuracy within 1 week

Is data accurate?

Yes	No
Notify Cheshire and Merseyside LMNS Clinical Lead Undertake a desk top review with external representation: Themes and learning	Confirm new verified data to information source of flagging outlier status or spike
Submit full report including summary of cases, key themes identified, learning and action plan.	Action plan to improve data accuracy
Submit full report to Cheshire and Merseyside LMNS Quality Surveillance Group.	Submit monthly updates on action plan to Cheshire and Merseyside LMNS until action plan completed.

WHH Clinical Governance Reporting Structure

Trust Board

Quality Assurance Committee
(Led by Non Executive Director)

Patient Safety and Clinical Effectiveness Sub Committee

Clinical Business Unit and Speciality Governance Meetings

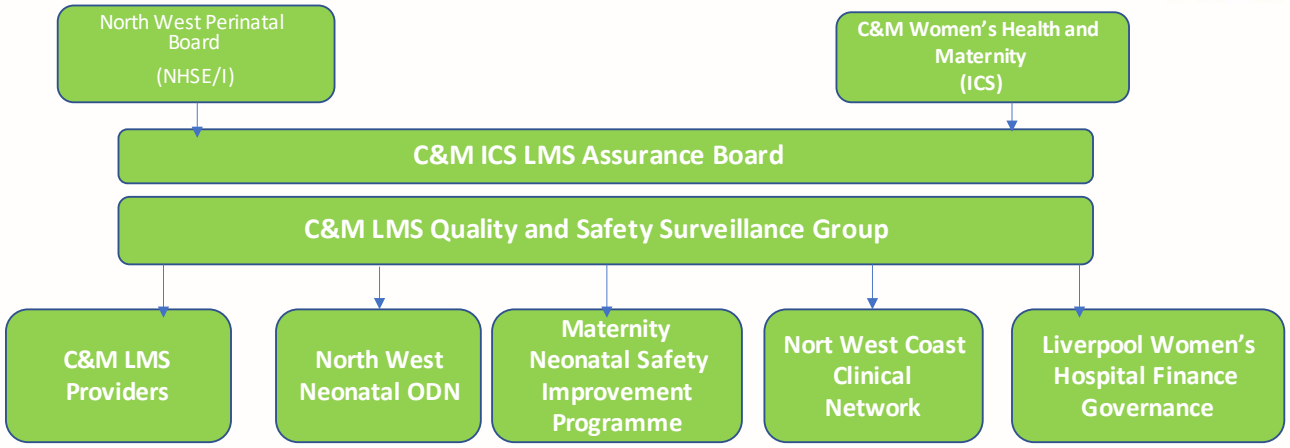
- Quarterly report of position and assurance provided to LMNS quarterly

Women's, Children's and Maternity Internal Governance Structure

Women's Health Governance Maternity & Gynaecology	Child's Health Governance Neonatal & Paediatric
• Intrapartum Care Forum • Perinatal Mortality Review (PMRT) • Ockenden Oversight Group • Maternity Incentive Scheme Group • Moving to Outstanding – mock undertaken	• Avoidance of term admission in neonatal Unit • Transitional Care • Child Health Improvement Group

Maternity & Neonatal Safety Champions & Maternity Voice Partnership

ICB Proposed Structure



Meet the Maternity and Neonatal Safety Champions

3. RECOMMENDATIONS

The Trust Board is requested to note the information of this paper.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/07/90 iv**	
SUBJECT:	**Ockenden Update**	
DATE OF MEETING:	**27th July 2022**	
AUTHOR(S):	Catherine Owens, Director of Midwifery/Associate Chief Nurse	
EXECUTIVE DIRECTOR SPONSOR:	Kimberley Salmon-Jamieson, Chief Nurse & Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	X X X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#1215** Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment. **#145** Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.	
EXECUTIVE SUMMARY *(KEY ISSUES):*	The initial Ockenden Report (December 2020) presented the findings on an inquiry into maternity care at Shrewsbury and Telford NHS Trust following a letter from families raising concerns about significant harm and deaths of neonates and mothers. Following this 7 Immediate and Essential Actions were recommended to improve safety within maternity services and improve the experience of women and families. 1 Enhanced Safety 2 Listening to women and their families 3 Staff training and working together 4 Managing Complex Pregnancies 5 Risk Assessment throughout pregnancy 6 Monitoring fetal well being 7 Informed Choice	

Warrington and Halton Teaching hospitals (WHH) has embedded the recommendations of Ockenden Part 1 and reported 95% compliance to Cheshire and Mersey Local Maternity and Neonatal System (C&M LMNS) on 15th April 2022.

The remaining actions are in relation to:

- Completion of a Maternity and Neonatal Safety Improvement Programme which WHH is due to commence in September 2022.
- LMNS have extended the deadline of an action in relation to the establishment of maternal medicine centres until September 2022.

Ockenden Part 1 phase 2

Following the initial evidence submission to the National Maternity Team the returned provider report identified a further 122 actions were identified. WHH is currently 86.89% compliant. The action plan is on track to be completed by 30th September 2022.

Ockenden Part 2 report

Ockenden Part Two was launched on 30th March 2022 and reported on the care provided to 1862 families examined during the investigation and identified internal and external factors that may have contributed to failings in care.

The report concluded by recommending all Trust's embed a further 15 Immediate and Essential Actions (IEA's) which encompass 92 actions:

1. Workforce Planning & Sustainability
2. Safe Staffing
3. Escalation & Accountability
4. Clinical Governance Leadership
5. Clinical Governance Learning from Clinical Incidents & Complaints
6. Learning from Maternal Death
7. Multidisciplinary Training
8. Complex Ante Natal Care
9. Pre-Term Birth
10. Labour & Birth
11. Obstetric Anaesthesia
12. Post Natal Care
13. Bereavement Care

	14. Neonatal Care 15. Supporting Families WHH Ockenden Part Two action plan was shared with C&M LMNS on 30th June 2022. This action plan was shared with the Executive team for information on 12th July 2022. An Ockenden Part Two Oversight Group was established in May 2022 to oversee the implementation. The group members include the Chief Nurse/Deputy Chief Executive Officer and Director of Governance. This action plan is also monitored by Women's and Children's Governance meetings. Currently there are no national timelines in which to submit Ockenden Part Two evidence or complete actions. No Risks have been identified which will inhibit WHH from implementing all 15 IEAs.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to note the findings of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome	Noted for information		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Ockenden Update	AGENDA REF:	

1. BACKGROUND/CONTEXT

In December 2020 Donna Ockenden released the first report and recommendation of 7 Immediate and Essential Action's (IEA's) from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust:

1 Enhanced Safety
2 Listening to women and their families
3 Staff training and working together
4 Managing Complex Pregnancies
5 Risk Assessment throughout pregnancy
6 Monitoring fetal well being
7 Informed Choice

Warrington and Halton Teaching Hospitals (WHH) has embedded an action plan (Appendix 1) and reported 95% compliance to the Cheshire and Mersey Local Maternity and Neonatal System on 15th April 2022.

Following the submission of Ockenden Part 1 evidence to the National Maternity Team on 15th July 2021, a further 122 actions were identified within the WHH provider report. A further action plan was developed to monitor the progress of the actions. This action plan can be seen in Appendix 2.

On 30th March 2022 Donna Ockenden released the 2nd part of the independent review which explored all 1862 families and the internal and external factors which may have contributed to the failings of care, outcomes and experiences of the families. Ockenden Part Two report (Appendix 3) recommends a further 15 IEAs to improve the safety of maternity services:

1. Workforce Planning & Sustainability
2. Safe Staffing
3. Escalation & Accountability
4. Clinical Governance Leadership
5. Clinical Governance Learning from Clinical Incidents & Complaints
6. Learning from Maternal Death
7. Multidisciplinary Training
8. Complex Ante Natal Care
9. Pre-Term Birth
10. Labour & Birth
11. Obstetric Anaesthesia
12. Post Natal Care
13. Bereavement Care
14. Neonatal Care

15. Supporting Families

Within the 15 IEA's the report includes an additional 92 actions to be embedded in to maternity providers.
Cheshire and Mersey Local Maternity and Neonatal System developed an action plan to support providers in the implementation of the 15 IEAs (Appendix 2). WHH has 78 actions to be completed and the remaining 11 actions are to be completed by the National Maternity Team.

The Ockenden Part Two Oversight Group was established in May 2022 and is chaired by the Chief Nurse/Deputy Chief Executive Officer and includes the Director of Governance. This group meet bi monthly and updates are reported into the Quarterly Maternity Update Report which is presented to Quality Assurance Committee and Trust Board.

This paper will update the Trust Board of the current overall Ockenden position.

2. KEY ELEMENTS

Ockenden Part 1 current position

Previously the Board have been informed WHH has embedded 95% of the recommendations made in Ockenden Part 1.

WHH remains 95% compliant. The remaining actions are in relation to:

- Completion of a Maternity and Neonatal Safety Improvement Programme which WHH is due to commence in September 2022.
- LMNS have extended the deadline of an action in relation to the establishment of maternal medicine centres until September 2022.

Ockenden Part 1 phase 2

Each Trust submitted the evidence in relation to Ockenden 1 recommendations on 15th July 2021. Following this when the evidence had been reviewed by National Health England Clinical Support Unit (NHSE/CSU) a further 122 actions were identified and requested to be embedded.

WHH have developed a further action plan (Appendix 2) and report 86.89 % compliance.

WHH Ockenden Part 1 phase 2 actions:

Key	Action
Purple	Action not initiated
Red	Action initiated but risk to achieving completion date
Amber	On track to achieve completion date
Green	Complete but assurance embedded not received

Blue	Complete, assurance evidence embedded, received and passed to CBU for monitoring
Grey	National Action

Key	Action	Number of actions	WHH %	National %
Purple	Action not initiated	0	0	
Red	Action initiated but risk to achieving completion date	0		
Amber	On track to achieve completion date	12	12.29	
Green	Complete but assurance embedded not received	8	6.56	
Blue	Complete, assurance evidence embedded, received and passed to CBU for monitoring	98	80.33%	
Grey	National Actions	1		0.82%
Total	WHH Actions to complete	122		
	WHH Overall Compliance		**86.89%**	

WHH remaining actions are in relation to:

IEA 1 Perinatal Quality Surveillance Model Standard Operating Procedure: A Cheshire and Mersey
Standard Operating Procedure has been developed and is going through WHH governance
process to be ratified locally. This action will be completed by 30th July 2022.

IEA 2 Trust Safety Champions share minutes with LMNS: currently awaiting process to be established
with LMNS to share Safety Champions minutes of Bi Monthly meetings.

IEA 3 Mandatory Training funding to be ringfenced and trust to provide finance audit; this must be
signed off by Director of Finance. This action will be complete by 21st July 2022.

IEA 4 Implementation of a maternal medicine's pathway. This is an action for the LMNS.

IEA 4 Compliance with all elements of Saving Babies Lives Version 2 care bundle: WHH has implemented all elements of the care bundle. The amber status is in relation to data assurance. A new BadgerNet system was implemented in May 2022. Data is reported monthly to the Cheshire and Mersey Region. Previous reporting of SBLV2 data has been escalated to Board regarding inter-operability issues with the previous maternity

data system. Data has been extracted from Badgernet however due to the timeline we are awaiting confirmation from the region to report assurance of our data.

IEA 6 Consultant Lead for fetal surveillance: WHH does have a named consultant for fetal surveillance however due to competing clinical demand is unable to completely fulfil all elements of this role. The Women's and Children's Clinical Business Unit is recruiting to this role.

IEA 7 Completion of an Out of Guideline audit: WHH recruited to a Consultant Midwife in April 2022 who has set up Out of Guideline Clinics from June 2022? This action will be completed by 30th September 2022.

IEA 7 Shared Decision Making: An electronic audit via Badgernet was undertaken which showed gaps in the data compliance. This has now been made a mandatory field and the audit will be repeated in 1 month.

Ockenden Part 1 phase 2 action plan is on trajectory to be completed by 30th September 2022

Ockenden Part 2 Current Position

The Ockenden Part Two action plan can be seen as appendix 3; each action has been colour coded as follows:

WHH Ockenden Part 2 Actions:

Key	Action
Purple	Action not initiated
Red	Action initiated but risk to achieving completion date
Amber	On track to achieve completion date
Green	Complete but assurance embedded not received
Blue	Complete, assurance evidence embedded, received and passed to CBU for monitoring
Grey	National Actions

Key	Action	Number of actions	WHH %	National %
Purple	Action not initiated	6	7.69	6.5
Red	Action initiated but risk to achieving completion date	1	1.28	1.08

Amber	On track to achieve completion date	46	58.96	23.9
Green	Complete but assurance embedded not received	13	16.66	13.54
Blue	Complete, assurance evidence embedded, received and passed to CBU for monitoring	12	15.38	12.5
Total	WHH Actions to complete	**78**		
	WHH Overall Compliance	**25**	**32.04**	
Grey	National Action	11		15.21
Total		89		100%

WHH IEA trajectory:

IEA No.	Immediate and Essential Action	WHH remaining actions on track to be completed by
1	Workforce Planning & Sustainability	December 2022
2	Safe Staffing	December 2022
3	Escalation & Accountability	October 2022
4	Clinical Governance Leadership	January 2023
5	Clinical Governance Learning from Clinical Incidents & Complaints	Complete with ongoing actions
6	Learning from Maternal Death	National Actions
7	Multidisciplinary Training	December 2022
8	Complex Ante Natal Care	September 2022
9	Pre-Term Birth	January 2023
10	Labour & Birth	November 2022
11	Obstetric Anaesthesia	December 2022
12	Post Natal Care	November 2022
13	Bereavement Care	October 2023
14	Neonatal Care	November 2023
15	Supporting Families	October 2022
In summary all WHH actions are on track to be completed by January 2023		

No risk has been identified in preventing WHH from embedding all 15 IEAs as recommended by Ockenden Part Two by the end of January 2023.

Summary

Ockenden Part One was launched in 2020 and recommended 7 IEAs. WHH reported 95% compliance to the C&M LMNS on 15th April 2022.

Ockenden Part 1 phase 2 action plan was developed following the initial feedback received from NHS CSU which identified a further 122 actions. WHH is compliant with 86.89% of all actions and is on track to be fully compliant by 30th September 2022.

Ockenden Part Two was launched on 30th March 2022 and recommended 15 additional IEAs. WHH is compliant with 32.04% of all actions and is on track to be fully compliant by 31st January 2023.

3. MONITORING/REPORTING ROUTES

Ockenden action plans are monitored by Woman's and Children's Governance Meeting, Ockenden Oversight Group and Moving to Outstanding meeting.

4. RECOMMENDATIONS

The Trust Board is asked to note WHH Ockenden position for information as per Ockenden recommendations.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/07/91**	
SUBJECT:	**Trust Engagement Dashboard Q2 2022 Apr-Jun**	
DATE OF MEETING:	27 July 2022	
AUTHOR(S):	James Bates, Interim Head of Communications	
EXECUTIVE DIRECTOR SPONSOR:	Pat McLaren, Director of Communications & Engagement	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	X X X
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	NA	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Engagement Dashboard is for the period Apr-Jun 2022 inclusive (Q1) and is linked to the CQC's Well Led Framework (KLOE 7.) It also incorporates Engagement and Involvement activity. The dashboard provides metrics relating to: • Level of success in managing the Trust's reputation in the media and across digital and social platforms • Our engagement and involvement with patients, staff and public via our social media channels • The Trust's website and levels engagement with this key platform • Patient enquiries via our website • Patient/public feedback on the independent platforms • Patient and Public Involvement and Participation, including our new Experts by Experience programme • Staff Communications **Media** 1. **Media** 165 media articles/broadcast items about the Trust in Q1 *(186 in Q3)* Sentiment - much positive media coverage relating to key initiatives including: a. Refugee nurses b. Endoscopy accreditation c. Visiting changes d. New Hospitals Programme e. SC thanking local population f. Major Expansion for Warrington Hospital AE g. Supporting staff absences h. PACU award	

	Social Media 1. During Q1, there were a total of 1,061 social posts across three social media channels (Facebook, Twitter and Instagram) 2. WHH social media channels reached an audience of over 500k, with a combined following of 26k **Website** 1. **Website visits** - the Trust's website sees continued growth with 48K in April, 54K in May and 47K in June (*Website peak during 2021 was peak 50K in December)* 2. **Website pages**: Most visited page is Covid-19 stats followed by Maternity, Contact us and blood test clinic. 3. **Website referrals**: 56.84% of visits came directly from Google *(Referrals sources steady against Q3*) **Engaging with and Involving our community** 1. A six week public consultation on the reconfiguration of our breast services took place in Q1 and closed with 163 responses – scrutiny and oversight is underway. 2. The Working with People and Communities Strategy 22-25 was completed and approved at Trust Board in May 22 3. The Experts by Experience programme is up and running with 8 patient representatives recruited to various services in the quarter. **Patient Feedback** 1. During Q1, there were 36 reviews about the Trust on key feedback platforms of which 58% were positive. (*This compares with 21 reviews in Q3 of which 84% were positive*) In addition to the traditional platforms (NHS Choices, Care Opinion and I Want Great Care) Google reviews are becoming more commonly used 2. **Healthwatch** continues to collect ratings on healthcare services in each borough, Halton Hospital is at 4.5*, RUTC is at 4.5* and Warrington Hospital is at 3*. (*These ratings are unchanged from Q3*)

PURPOSE: *(please select as appropriate)*	Information X	Approval	To note X	Decision
RECOMMENDATION:	The Trust Board is asked to note the Engagement dashboard and new metrics linked to KLOE7 in the CQC's Well Led framework.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

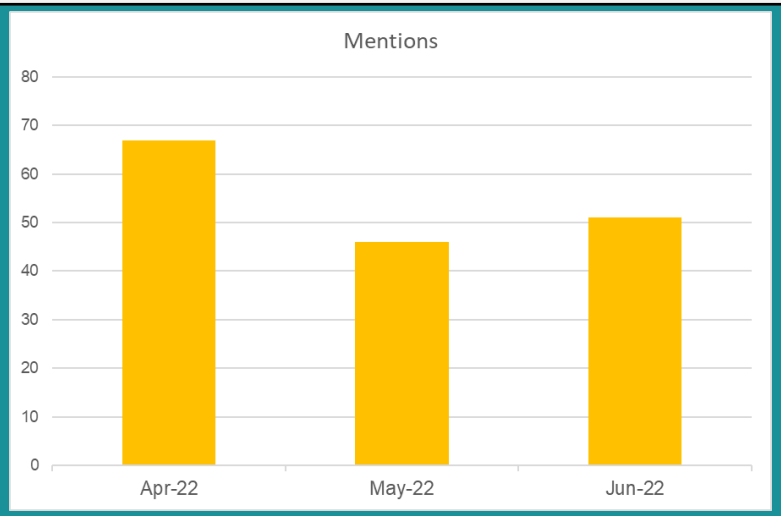
NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

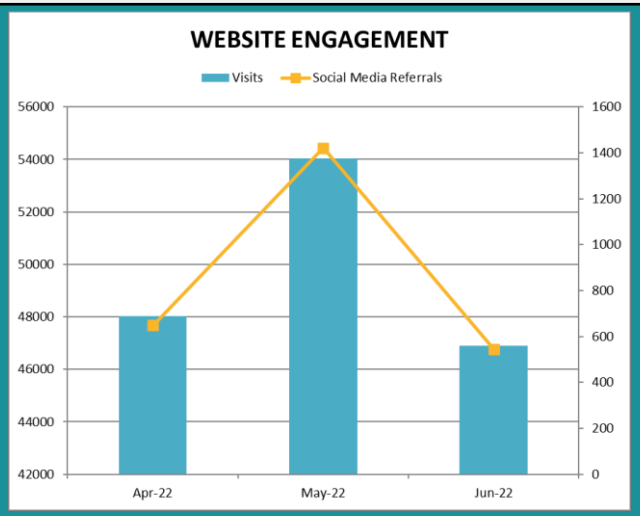
WHH Communications, Engagement and Involvement

Dashboard Q1 April – June 2022

‘Well-Led’ KLOE 7: Communicating with the Public

Metric	Media coverage Visits to the public website
Current Performance	During quarter one, there were **165 media** articles/broadcast items about the Trust. **Top positive news stories:** • *Endoscopy at Halton Hospital rated among UK’s best thanks to passionate staff* • *How Warrington Hospital is supporting staff as stress absences across NHS soar* • *Award for innovative Warrington and Halton hospitals unit* **Most viewed/shared negative news stories**: • *Inquest hears further details over death of Warrington teenager in hospital* • *Warrington and Halton hospitals broke NHS rules more than a dozen times - still far better than national average* Website: ‘COVID-19 current status’ continues to be the most visited **website** pages, followed by Maternity Services
Actions / Comments	• Media coverage was largely positive during quarter one, mainly attributed to the Endoscopy at Halton Hospital and action on staff wellbeing. • Q1 seen that ‘COVID-19 current status’ was the most visited web page with 16,108 views. The peak was Tuesday 10 May 2022. • 56.84% of those visits came directly from Google.

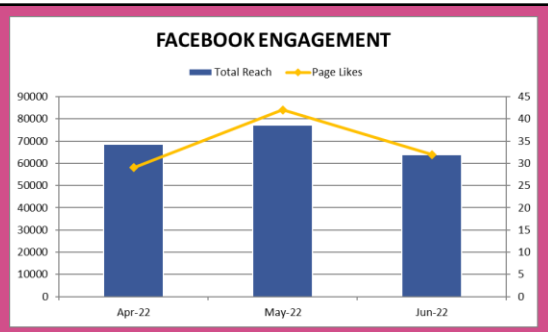


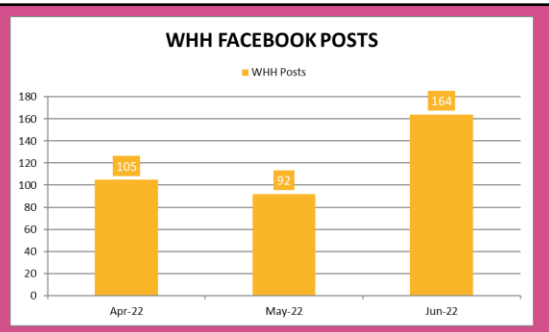


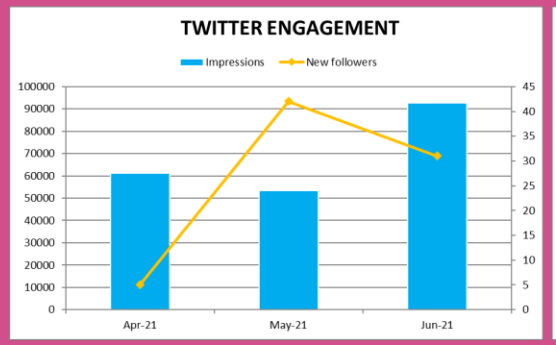
Website visits: most popular sections	345,318
/	36,429
/Covid-19 status	16,108
/Maternity	8,327
/Contact us	8,227
/Blood test clinic	7,624
/Services	7,002
/Halton General Hospital	6,480
/home	6,463
/visiting and facilities	6,352

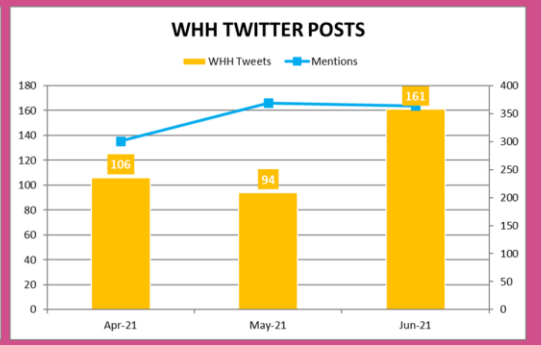
‘Well-Led’ KLOE 7: Communicating with the public

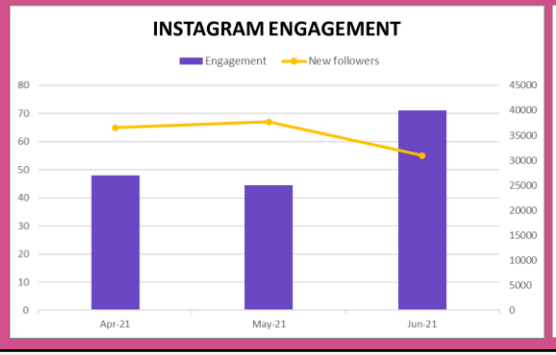
Metric	Social media posts, engagement and sentiment
Current Performance	This quarter, there were a total of 1,061 social posts across three social media channels (Facebook, Twitter and Instagram) WHH social media channels reached an audience of over 500k, with a combined following of 26k
Top Posts for Engagement	 

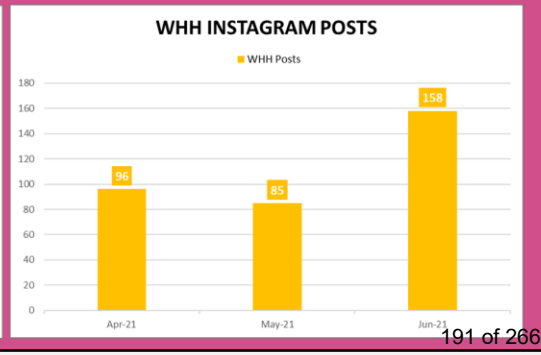












‘Well-Led’ KLOE 7Metrics: Engaging with and Involving our community

Metric	Engagement opportunities
Current Performance	

Public Consultations:

Reconfiguration of Breast Services (Phase 2)

- A six week public consultation on the reconfiguration of our breast services
- Face to face and virtual consultation, printed and online materials and questionnaires
- Consultation with stakeholders, partners and advocacy groups, with follow up comms to specific groups in our community who are typically less well represented.
- consultation received 162 responses which were representative of our local residents

Engagement:

- **Working With People and Communities Strategy 2022-2025**
- Refresh of Patient and Public participation and Involvement (PPP&I) Strategy 2022-25 has been refreshed and renamed following engagement with stakeholders and is now titled Working with People and Communities Strategy.
- Annual Deployment plan in development

Governors Engagement Group

- Face to face meetings recommenced.
- Governor Action Plan and four priorities.. Governor Engagement and Promotion, Hospital Food, Patient letters/accessible Information, Patient and Public Engagement and Involvement
- Governor Guide to Engagement produced.

Experts by Experience (EbyE)

- **E**byE request Form now available on Extranet and recruitment form on Trust Website
- 8 Experts by Experience have been recruited - 1 to EDI Metric Steering Group, 3 to patient Letters Task and Finish Group, 2 Green Plan/Zero Carbon patients Pilot, 2 Estates and First Impressions project

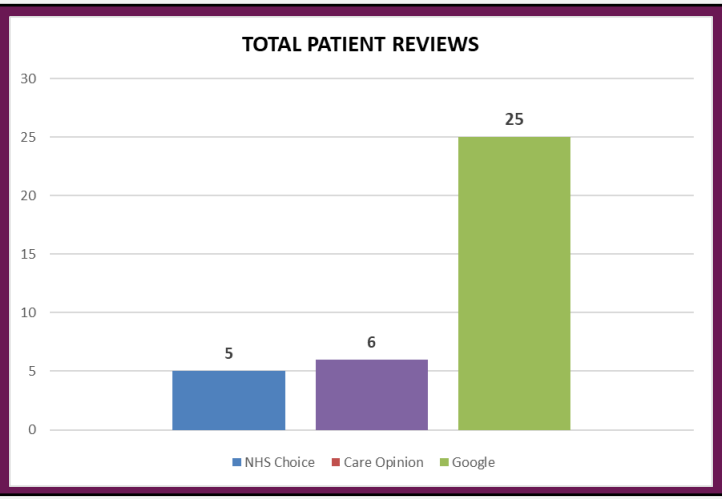
Social Value:

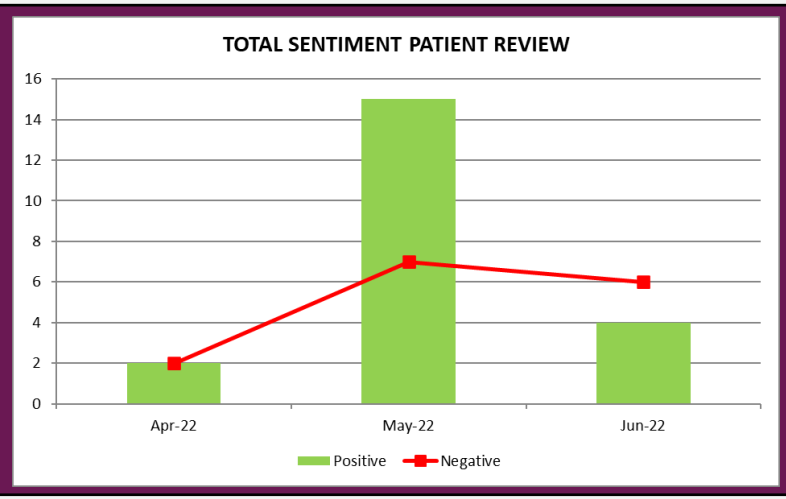
Platinum Jubilee Celebrations

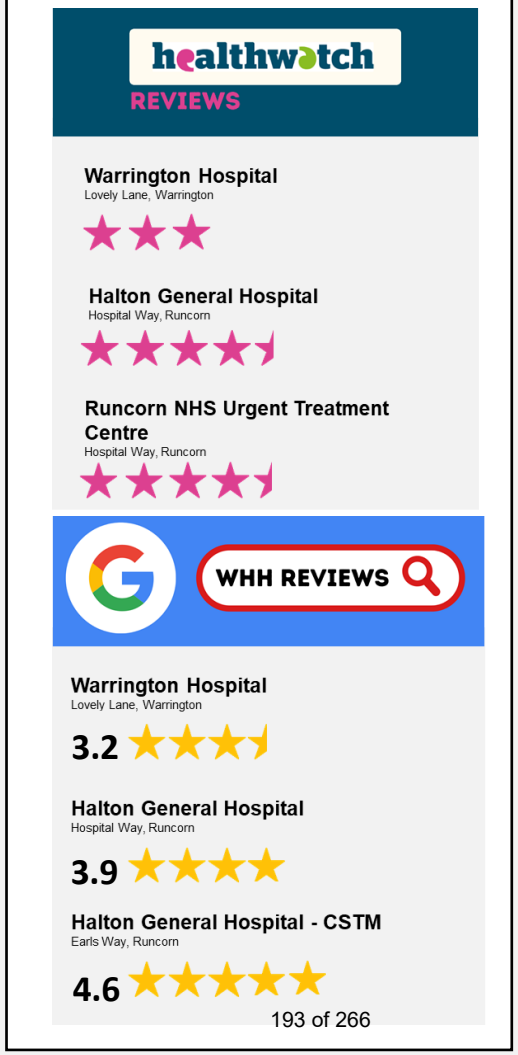
- WHH Charity held an event on Thursday 26th May which brought our community, patients and staff together in celebration of the Queen’s Platinum Jubilee.
- Sacred Heart Primary School created a wall of beautiful commemorative posters/plates and poems, which were proudly displayed within the main entrance of Warrington Hospital throughout the lead up to the Jubilee weekend.

‘Well-Led’ KLOE 7 Metrics : Patient engagement through public channels and media

Metric	**ENGAGEMENT WITH FEEDBACK CHANNELS** Feedback include channels in the public domain : Google reviews, NHS Choices, Care Opinion
Current Performance	In Q1 there were 36 reviews about the Trust of which 58% were positive.
Actions / Comments	**Top online source for public feedback:** Google reviews **General Theme:** A&E is most reviewed both positively and negatively **Positive feedback:** “I cannot thank the staff at A & E enough last night. They were fantastic from start to finish. From triage staff who were so caring and reassuring from the start, to a reception staff member asked if I was ok a couple of hours into the wait time (that was so lovely of you). There was no ‘cold’/‘just a number’ treatment just warmth and compassion for my situation. The doctor who I will name L - I have not received doctor care like that for many years - you’re thoroughness/care and dedication to your role are evident. Obviously they need a lot more staff they are so stretched. However, I cannot tell you how much I appreciated being at Warrington hospital and feeling so looked after. Thank you”

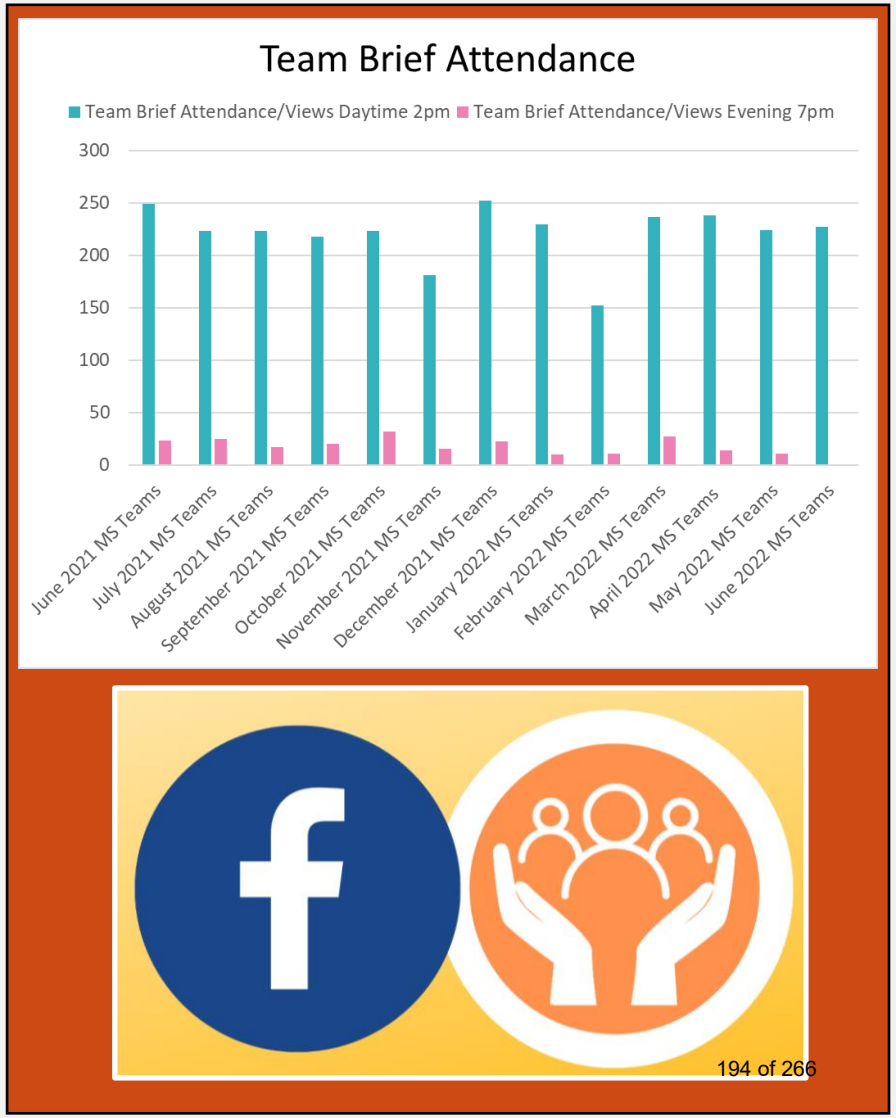






‘Well-Led’ Metrics : Communicating with staff

Metric	**Engagement with Staff Communication Channels** Trust-wide staff communications channels include: The Daily Safety Brief Good Morning WHH from the CEO The Week A closed staff-only Facebook group WHH People Monthly Team Brief Extranet announcements (NEW) Staff App – currently being trialled by 50+ staff
Current Performance	**TEAM BRIEF TOTAL ENGAGEMENT FOR 2021-22** Attendance • 2pm slot - 689 • 7pm slot - 25 • April saw the highest attendance, top story – the rise in Emergency care patients **MEMBERS ON WHH PEOPLE FB PAGE** 608 staff members. **STAFF APP – NEW – COMING SOON** • App downloads (this will be cumulative) • Most viewed pages



REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/07/92**	
SUBJECT:	**Use of Resource Assessment (UoRA) Update – Q1 2022/23**	
DATE OF MEETING:	27th July 2022	
AUTHOR(S):	Dan Birtwistle, Deputy Head of Contracts & Performance	
	Alice Forkgen, Associate Director of Finance	
EXECUTIVE DIRECTOR SPONSOR:	Andrea McGee, Chief Finance Officer and Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	**#134** Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern.	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust continues to progress improvement in its Use of Resources both internally and in collaboration with system wide partners. This paper outlines the current status of the Use of Resources Dashboard. It should be noted that a number of the indicators have not been updated on the Model Hospital. This report also contains the progress on the findings of the 2020/21 Corporate Benchmarking exercise.	

PURPOSE: ***(please select as appropriate)***	Information	Approval	To note	Decision
			x	

RECOMMENDATION:	The Board of Directors is asked to: 1. Note the contents of this report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	

FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.

REPORT TO THE BOARD OF DIRECTORS

SUBJECT	Use of Resource Assessment (UoRA) Update – Q1 2022/23	AGENDA REF:	BM/22/07/92

1. BACKGROUND/CONTEXT

The Use of Resource Assessment (UoRA) is designed to improve understanding of how effectively and efficiently the Trust uses its resources. The UoRA is based on 5 key lines of enquiry (KLOEs) these are; clinical services, people, clinical support services, corporate services and finance. The UoRA workstream has prepared narrative for each KLOE and has developed a dashboard. This forms the basis from which to review and improve each KLOE indicator.

UoRA data is from the Model Hospital and has been benchmarked against peer and national median groups. The RAG rating is based on the Trust's position against the national median on the model hospital. The peer median group is based on NHSI's peer finder tool.

2. KEY ELEMENTS

This paper presents the update for Quarter 1 2022/23. Performance against each UoRA KLOE is set out in **Appendix 1**, the full detail for each KLOE indicator can be found in **Appendix 2**.

The following movements have taken place on the UoRA Dashboard since Quarter 4 2021/22:

- Staff Retention – the Trust has moved from Green to Red for this indicator. However as previously reported, an issue has been identified and reported to the model hospital as the data across the various Trusts is very high when compared to Trust data (for March 2022, the model hospital has the Trust retention data at 97.90%, the Trust's own data for the same time period was at 83.70%).

3. CORPORATE BENCHMARKING

3.1 Background

Corporate benchmarking is undertaken on an annual basis. The latest report issued in December 2021 presented the results of the 2020/21 benchmarking exercise. There was no benchmarking exercise undertaken in 2019/20 due to the COVID-19 pandemic and therefore comparisons can only be made against 2018/19 data.

All Trusts were asked to submit a wide range of data and information, including cost, staffing, quality and process metrics relating to the following corporate services functions:

- Finance
- Governance and Risk
- HR
- IM&T
- Payroll
- Procurement

This corporate benchmarking exercise is a comparison of cost per £100m and does not take into account any other factors such as quality, productivity, outcomes or the level of risk managed.

3.2 Overall Trust Position

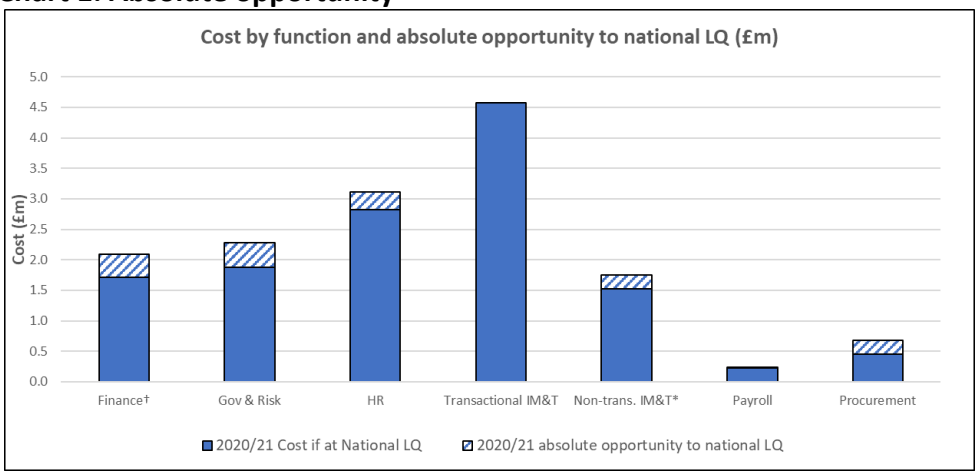
The benchmarking report shows there has been an overall increase of £0.36m in corporate costs, however, costs per £100m income have reduced by £1.26m. This reflects the change in the NHS financial regime and additional income received due to COVID-19. The Trust's total income in 2020/21 was £317m compared with £243m in 2018/19. See **Table 1** for a summary of the results.

Table 1: Summary of 2020/21 results and comparisons to 2018/19 results

Function	2020/21				2018/19	
	Cost (£m)	Cost per £100m		Absolute opportunity to national LQ (£m)	Cost (£m)	Cost per £100m income
		Trust value (£m)	National LQ (£m)			
Finance	2.09	0.66	0.54	0.38	2.04	0.84
Gov & Risk	2.29	0.72	0.59	0.41	2.43	1.00
HR	3.11	0.98	0.89	0.29	2.65	1.09
Transactional IM&T	4.55	1.43	1.44	Not Available	4.53	1.86
Non-trans. IM&T	1.75	0.55	0.48	Not Available	1.80	0.74
Payroll	0.24	0.08	0.07	0.02	0.24	0.10
Procurement	0.68	0.21	0.14	0.22	0.66	0.27
Total	14.70	4.63	4.15	1.32	14.34	5.89

The cost per £100m income for each of the corporate functions has improved since the 2018/19 review. The benchmarking results also compare the Trust costs against the national lower quartile (LQ) which identifies any absolute opportunity for efficiency savings. **Chart 1** shows the total cost of the seven corporate services functions for 2020/21. Where the 2020/21 cost per £100m income for a function is above the national lower quartile, the bar is split to show the Trust's theoretical cost if it matched that benchmark.

Chart 1: Absolute opportunity



In addition to the national LQ, the report also provides comparison against the national median, national upper quartile (UQ) and LQ, median and UQ of the ICS. See **Table 2** for full details.

Table 2: Comparison of Trust costs versus National and ICS LQ, Median and UQ

Cost per £100m Income	2018/19 WHH	2020/21 WHH	National LQ	National median	National UQ	ICS LQ	ICS median	ICS UQ
Finance	838.9k	**658.0k**	539.5k	635.6k	751.7k	658.0k	709.6k	786.3k
Governance & Risk	998.6k	**720.5k**	591.6k	784.9k	1,138.7k	720.5k	902.3k	966.0k
HR	1,087.6k	**980.2k**	887.9k	1,064.3k	1,348.3k	945.8k	1,066.1k	1,361.6k
IM&T	2,600.0k	**1,986.0k**	2,042.0k	2,571.8k	3,309.6k	2,556.3k	2,840.7k	3,355.9k
Payroll	97.0k	**75.2k**	70.4k	86.3k	110.3k	75.2k	111.7k	122.7k
Procurement	271.6k	**212.8k**	142.5k	203.1k	262.8k	174.9k	203.8k	281.7k

KEY:
Green is where the Trust cost is below the comparative figure
Red is where the Trust cost is above the comparative figure
Blue is where the Trust cost equals the comparative figure

3.3 Progress of Review by Corporate Services

During quarter 1, each corporate service reviewed the benchmarking report results to identify any potential areas of efficiency based on the comparison with national and ICS LQ and median highlighted in **Table 2**.

Further detail relating to the review of each corporate service is set out in **Appendix 3.**

4. RECOMMENDATIONS

The Board of Directors is asked to:

1. Note the contents of this report.

Andrea McGee
Chief Finance Officer and Deputy Chief Executive
20th July 2022

Appendix 1 – Benchmarking Performance against the National Median

KLOE Indicator	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	Q1 22/23
KLOE 1 - Clinical																
Pre-Procedure Elective Bed Days	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q4 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q4 2021/22	Q4 2021/22
Pre-Procedure Non-Elective Bed Days	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q4 2020/21	Q4 2020/21	Q1 2021/22	Q2 20221/22	Q4 2021/22	Q4 2021/22
Emergency Readmission (30 Days)	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q4 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q4 2021/22	Q4 2021/22
Did Not Attend (DNA) Rate	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020/21	Q2 2020/21	Q4 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q4 2021/22	Q4 2021/22
KLOE 2 - People																
Staff Retention Rate	June 2018	September 2018	December 2018	December 2018	December 2018	December 2018	March 2020	March 2020	June 2020	Sept 2020	December 2020	March 2021	March 2021	September 2021	February 2022	March 2022
Staff Sickness	May 2018	August 2018	November 2018	November 2018	June 2019	October 2019	March 2020	March 2020	June 2020	Sept 2020	January 2021	March 2021	June 2021	September 2021	February 2022	March 2022
KLOE 3 – Clinical Support Services																
Top 10 Medicines - Percentage Delivery of Savings	March 2018	March 2018	March 2018	March 2018	September 2019	November 2019	March 2020	March 2020	August 2020	November 2020	February 2021	May 2021	July 2021	July 2021	July 2021	July 2021
Pathology - Overall Costs Per Test	Q4 2017/18	Q4 2017/18	Q2 2018/19	Q2 2018/19	Q4 2018/19	Q2 2019/20	Q3 2019/20	Q3 2019/20	Q3 2019/20	Q1 2020/21	Q3 2020/21	Q4 2020/21	Q4 2020/21	Q2 2021/22	Q3 2021/22	Q3 2021/22
Radiology Cost Per Report	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	March 2018	2020/21	2020/21	2020/21	2020/21
KLOE 4 – Corporate Services																
Finance Costs per £100m Turnover	2016/17	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2020/21	2020/21	2020/21
Human Resource Costs per £100m Turnover	2016/17	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2020/21	2020/21	2020/21

Procurement Process Efficiency and Price Performance Score Clinics	Q4 2016/17	Q4 2017/18	Q3 2018/19	Q3 2018/19	Q4 2018/19	Q4 2018/19	Q4 2018/19	Q4 2018/19	Q2 2019/20	Q2 2019/20	Q2 2019/20	Q2 2019/20	Q2 2019/20	Q2 2019/20	Q2 2019/20	Q2 2019/20
Estates Costs Per m2	2017/18	2017/18	2017/18	2017/18	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2019/20	2019/20	2020/21	2020/21	2020/21	2020/21

KLOE 5 - Finance	
Capital Services Capacity*	The model hospital does not benchmark these indicators against the national median and therefore there is no RAG rating available. The data on the model hospital has not been updated since February 2019.
Liquidity (Days)*	
Income & Expenditure Margin*	
Agency Spend - Cap Value*	
Distance from Financial Plan*	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

UoR

Use of Resource Graph Key

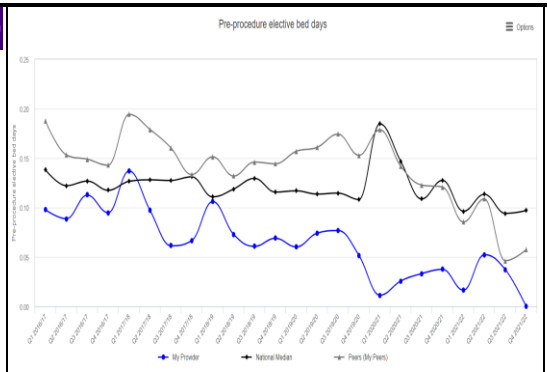
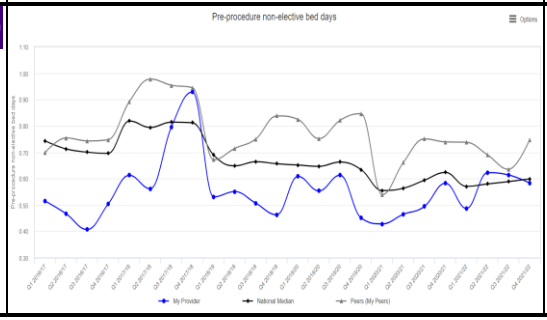
Trust Position	
National Median	
Peer Median	

Key

Green on the Model Hospital (Better than the National Median)
Red on the Model Hospital (Worse than the National Median)
Not RAG Rated on the Model Hospital

Appendix 2

Use of Resources Assessment Dashboard - Q1 2022/23

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
KLOE 1: Clinical/Operational			KLOE Operational Lead: Zoe Harris
Pre Procedure Elective Bed Days - The number of bed days between the elective admission date and the date that the procedure taken place.	**National Median: 0.10 days** Q4 2021/22 **Peer Median: 0.06 days** **Target: Maintain** **Best Quartile: 0.05 days** **WHH Position:** **0.00 days** **Ranking:** **01/09 Peer Group** **Quartile:** **1 (Best)** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	UoR		**The Trust is performing in the best quartile for this metric and is performing better than the national and peer medians.** The Trust continually reviews opportunities to provide same day admission. The surgical transformation programme supported the reduction in theatre cancellations and in improving productivity and efficiency. The position has been sustained throughout the COVID-19 pandemic and continues to be monitored.
Pre Procedure Non Elective Bed Days - The number of bed days between an emergency admission date and the date the procedure taken place.	**National Median: 0.60 days** Q4 2021/22 **Peer Median: 0.75 days** **Target: Best Quartile** **Best Quartile: 0.41 days** **WHH Position:** **0.58 days** **Ranking:** **03/09 Peer Group** **Quartile:** **2 (2nd Best)** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	UoR		**The Trust is performing better than the national and peer medians.** The Trust continually reviews opportunities to provide same day admission. The surgical transformation programme supported the reduction in theatre cancellations and in improving productivity and efficiency. The position continues to be monitored. There is a significant proportion of diagnostic procedures within medical specialties data.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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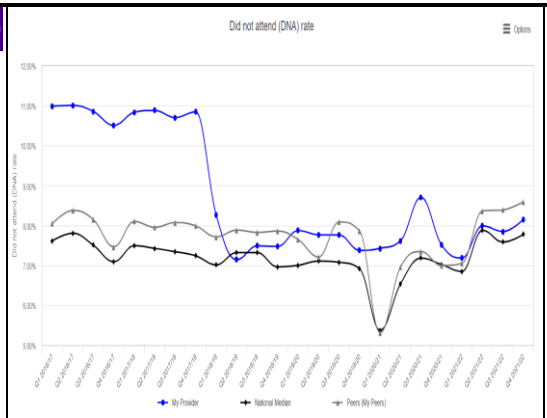
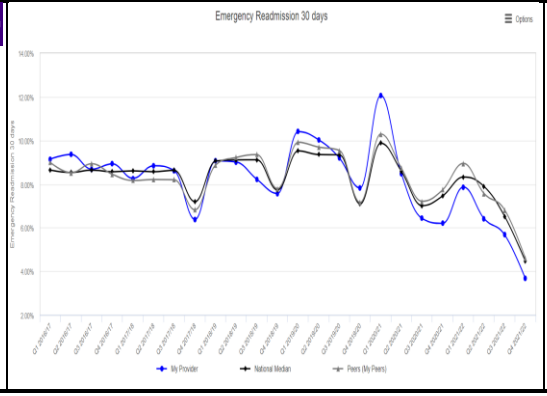
Use of Resources Assessment Dashboard - Q1 2022/23

Action/ Recommendation	Benchmarking/Progress		Trend	Narrative - Warranted/Unwarranted & Justifiable
Did Not Attend Rate - Rate of patients not attending their outpatient appointment	**National Median: 7.78%** **Peer Median: 8.59%** **Best Quartile: 6.26%** **WHH Position:** **Ranking:** **Quartile:** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q4 2021/22** **Target: National Median** **8.15%** **03/09 Peer Group** **3 (2nd Worse)**		**The Trust is performing worse than the national median but is performing better than the peer median.** The Trust has utlised several initiatives to support improvement in the DNA rate. This has proved challenging during the COVID-19 pandemic and the Trust continues to see seasonal variation and variances between specialties. The Trust has established the Outpatient Recovery Improvement Group incorporating 5 workstreams; Risk Stratification, Workforce, Performance & KPIs, Operational and Access Policy. DNA performance is monitored through the Performance & KPI workstream. The DNA policy have been reviewed and individual CBUs are monitoring frequent DNAs to ensure that these patients are clinically reviewed for potential discharge. Patient Initiated Follow Ups (PIFU) are also being utilised and will reduce DNAs. The Trust's Access Policy is currently under review.
Emergency Readmission Rates (30 Days) - This indicator measures the percentage of admissions of people who returned to hospital as an emergency within 30 days of the last time they left hospital after a stay. Admissions for cancer and obstetrics are excluded as they may be part of the patient's care plan.	**National Median: 4.47%** **Peer Median: 4.59%** **Best Quartile: 3.51%** **WHH Position:** **Ranking:** **Quartile:** **Monitoring: KPI Sub-Committee** **Source: Hospital Episode Statistics**	**Q4 2021/22** **Target: Maintain** **3.67%** **02/09 Peer Group** **2 (2nd Best)**		**The Trust is performing better than national and peer medians** Every effort is made when discharging a patient to ensure that the discharge is appropriate. Readmissions are reviewed by the clinical directors to understand any inappropriate discharges and to ensure lessons are learned. The Trust is fully engaged with GIRFT (Getting It Right First Time) and continues to use intelligence to make improvements in efficiencies and in the quality of services.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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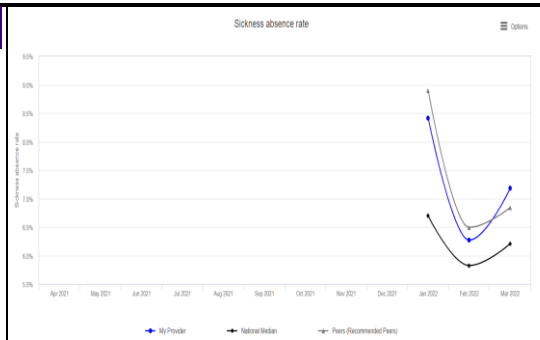
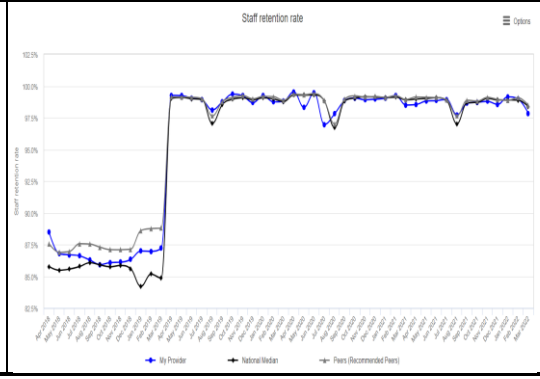
Appendix 2

Use of Resources Assessment Dashboard - Q1 2022/23

Action/ Recommendation | **Benchmarking/Progress** | **Trend** | **Narrative - Warranted/Unwarranted & Justifiable**

KLOE 2: People

KLOE Operational Lead: Carl Roberts

Staff Sickness - Percentage of staff FTE sick days.	**National Median: 6.2%** **March 2022** **Peer Median: 6.8%** **Target: 4.2%** **Best Quartile: 5.6%** **WHH Position:** **7.20%** **Ranking:** **07/11 Peer Group** **Quartile:** **4 (Worse)** **Monitoring: Trust Board, SPC** **Source: HSCIC - NHS Digital iView Stability Index**		**The Trust is performing worse than the national and peer medians.** Absence as at June 2022 is 6.25%, a 0.95% reduction from March 2022. This is following the launch of the Supporting Attendance Policy in February 2022 and the transition of all staff members to the new policy. There has also been increased education and support for managers and staff in Supporting Attendance. The top two reasons for absence are: • Anxiety/stress/depression/other psychiatric illnesses – which makes up 26% of absence days. • Chest and respiratory problems (COVID-19) – which makes up 20% of absence days. Benchmarking work with NHSEI and through a regional group continues. Key stakeholders across the People Directorate are included in a range a regional working groups to enable best practice sharing and collaboration.
Staff Retention Rate -The percentage of staff that remained stable over 12 months period.	**National Median: 98.4%** **March 2022** **Peer Median: 98.5%** **Target: National Median** **Best Quartile: 98.7%** **WHH Position:** **97.90%** **Ranking:** **11/11 Peer Group** **Quartile:** **4 (Worse)** **Monitoring: Board/SPC** **Source: HSCIC - NHS Digital iView Stability Index**		**The Trust is performing worse than the national median and in line with the peer median.** As of June 2022 Retention is 83.17% or 86.6% of permanent staff only. The known reasons staff are leaving are: • Work Life Balance • Retirement • Relocation • Promotion elsewhere A significant number of people delayed their retirement plans in 2020 and 2021, and are now choosing to retire. It is worth noting a number of retirees do return to the workplace (retire and return) and are supported to do so, however these still count as a leaver for the purposes of retention and turnover.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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National Median	
Peer Median	

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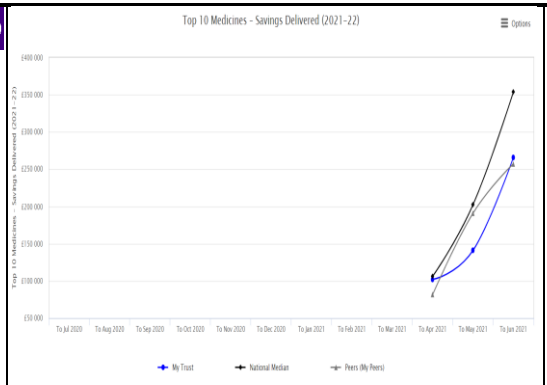
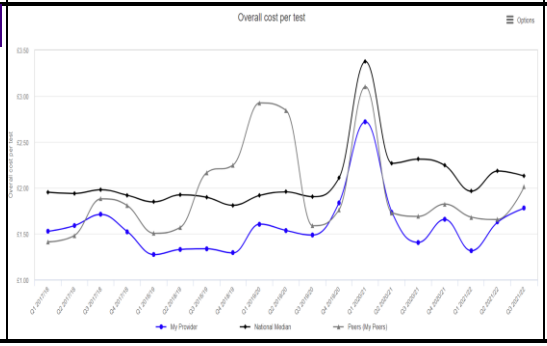
Appendix 2

Use of Resources Assessment Dashboard - Q1 2022/23

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable

KLOE 3: Clinical Support

KLOE Operational Lead: Diane Matthew
KLOE Operational Lead: Neil Gaskell
KLOE Operational Lead: Mark Jones

Top 10 Medicines - Percentage Delivery of Savings (Pharmacy)	**Benchmark: £125k** **Peer Median: £356k** **Best Quartile: N/A** **WHH Position:** **£311k** **Ranking:** **Quartile:** **N/A** **Monitoring: Medicines Governance Committee** **Source: Rx-Info Define© (processed by Model Hospital)**	**July 2021** **Target: Benchmark**		**The Trust is performing better than the national benchmark.** The Trust is exceeding the national benchmark and has achieved savings of £311k as of July 2021 (this is the latest available information on the Model Hospital). The Pharmacy Team ais working with Finance colleagues to review savings for 2021/22. The Trust maintains low drug costs in comparison with the national median e.g. £326/Weighted Activity Unit (WAU) compared with £687/WAU for Acute Trusts. Medicines optimisation remains a prioritised workstream. Processes continue to be aligned between the Trust, ICB/ICS and the Pan Mersey Area Prescribing Committee. Collaboration is ongoing to ensure opportunities for further improvements are identified. WHH is engaged in a ICS level medicines optimisation workstream which will look to collaborate on medicines efficiencies across the network.
Pathology - Cost Per Test - The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items.	**National Median: £2.13** **Peer Median: £2.01** **Best Quartile: £1.81** **WHH Position:** **£1.78** **Ranking:** **1/4 Peer Group** **Quartile:** **1 (Best)** **Monitoring: Pathology Business Meeting** **Source: NHSI Q Pathology Data Collection 21/22**	**Q3 2021/22** **Target: Maintain**		**The Trust is performing better than the national and peer medians and is in the best quartile for this metric.** Overall the Trust's pathology service is efficient with the use of streamlined processes, technology and procurement opportunities. The Trust continues to perform well with regards to overall cost per test during the recovery period following the COVID-19 pandemic.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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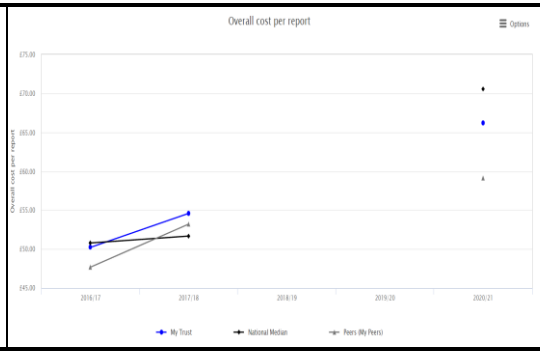
Use of Resources Assessment Dashboard - Q1 2022/23

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Imaging - Cost Per Report - Total cost of reporting one image, irrespective of modality	**National Median: £70.59** **2020/21** **Peer Median: £59.10** **Target: Maintain** **Best Quartile: £55.93** **WHH Position:** **£66.19** **Ranking:** **8/10 Peer Group** **Quartile:** **2 (2nd Best)** **Monitoring:** **Source: NHS Imaging Productivity Data Collection (Annual)**		**The Trust Imaging Cost Per Report is better than the national median.** The Trust has invested significantly in diagnostic equipment which has enabled the Trust to reduce its outsourcing of radiology including vascular. . This metric now reflects: 1. The move to bring Vascular Ultrasound in house in March 2021. 2. An increase utilisation of Radiographer Reporting within the department. 3. The cessation of outsourcing of reporting in late 2021.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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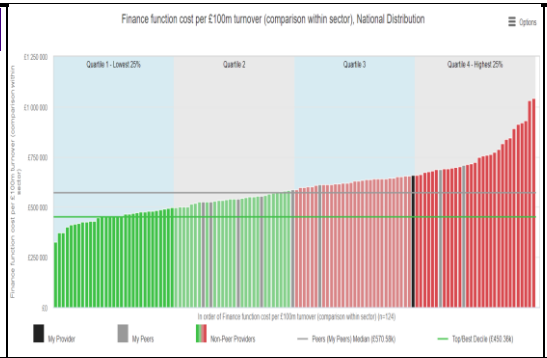
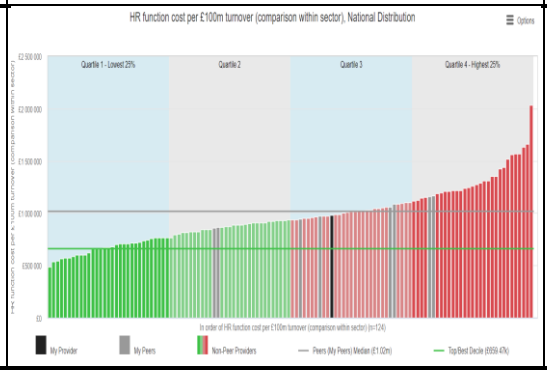
Use of Resources Assessment Dashboard - Q1 2022/23

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
KLOE 4: Corporate Services		Finance Procurement HR & OD Estates & Facilities	KLOE Operational Lead: Jane Hurst KLOE Operational Lead: Alison Parker KLOE Operational Lead: Carl Roberts KLOE Operational Lead: Ian Wright

Finance Costs per £100m Income - Total finance cost divided by trust turnover multiplied by a £100m	**National Median: £636k** **Peer Median: £570k** **Best Quartile: £586k** **WHH Position:** **£658k** **Ranking:** **7/9 Peer Group** **Quartile:** **3 (2nd Worse)** **Monitoring: FSC** **Source: Trust consolidated annual accounts and NHSI improvement 20/21 data collection template**	**2020/21** **Target: Benchmark**		**The Trusts Finance costs per £100m income are higher than the national and peer medians based on national benchmarking data from 2020/21**. The Trust has improved from £838k to £658k cost per £100m income which is £22k worse than the national median and £77k worse than the peer median. The Trust is reviewing the benchmarking data to understand the areas of variation and areas of improvement. Further investigation is required on how outsourced function costs are benchmarked. There are potential saving in some sub-functions through utilisation of automation and review of processes.
Human Resource Costs per £100m Income - HR is made up of a number of sub compartments taken into consideration when considering total HR costs per £100m turnover.	**National Median: £936k** **Peer Median: £1.02m** **Best Quartile: £888k** **WHH Position:** **£980k** **Ranking:** **5/11 Peer Group** **Quartile:** **3 (2nd Worse)** **Monitoring: SPC** **Source: Trust consolidated annual accounts and NHSI improvement 20/21 data collection template**	**2020/21** **Target: Benchmark**		**The Trusts HR costs per £100m income are higher than the national median and lower than the peer median based on national benchmarking data for 2020/21.** The Trust is reviewing the benchmarking data to understand the areas of variation and any areas for improvement.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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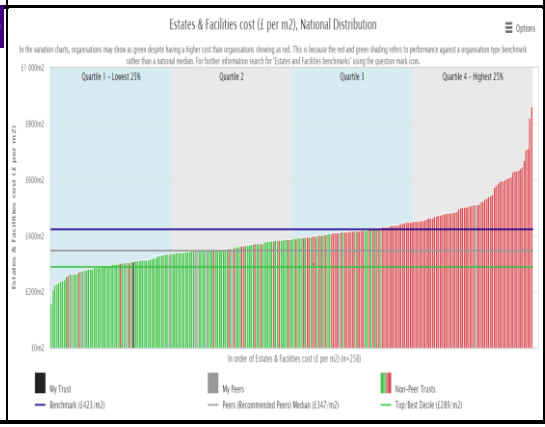
Use of Resources Assessment Dashboard - Q1 2022/23

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Procurement Process Efficiency and Price Performance Score - This measure provides an overall view of how efficient and how effective an NHS Provider is in it's procurement process and price performance, respectively, when compared to other NHS providers.	**National Median: 56** Q2 2019/20 **Peer Median: 44.7** Target: 72 **Best Quartile: 72** **WHH Position:** 61 **Ranking:** 4/11 Peer Group **Quartile:** 3 (2nd Best) **Source: Purchase Price Index and Benchmark (PPIB) tool**		**The Trust is performing better the national and peer medians for the Procurement Process Score.** Procurement metric reporting recommenced in February 2022 and the Trust now submits data monthly. The Trust is awaiting the model hospital to be updated which is expected in Q2 2022/23. Once this has been updated, the data will be analysed to understand the current position. It is anticipated that benchmarking data will only be available from April 2022 onward for the new metrics.
Estates & Facilities Costs (£ per m2) - The total estates and facilities running costs is the total cost of running the estate in an NHS trust including, staff and overhead costs. In-house and out-sourced costs, including PFI costs, will be included.	**Benchmark: £423** 2020/21 **Peer Median: £347** Target: Maintain **Best Quartile: £321** **WHH Position:** £308 **Ranking:** 4/11 Peer Group **Quartile:** 1 (Best) **Monitoring: Estates and Facilities Operational Group** **Source: ERIC 2020-21 Total Estates and Facilities Running Costs**		**The Trust Estates and Facilities costs are better than the national benchmark and the peer median.** The Trust has invested year on year to reduce backlog maintenance. The Trust has received the outcome of the ERIC return (for 2020/21) and the Trust continues to benchmark well in overall Estates & Facilities costs.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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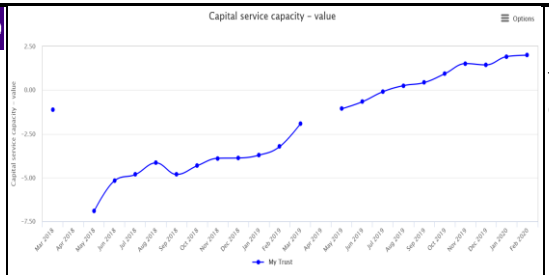
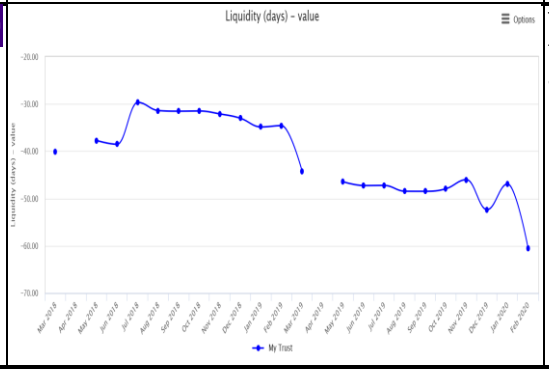
Use of Resources Assessment Dashboard - Q1 2022/23

KLOE 5: Finance

KLOE Operational Lead: Jane Hurst

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Capital Services Capacity - The degree to which the provider's generated income covers its financial obligations	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital 1.99 (February 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		Use of Resource (Finance) reporting has been suspended since March 2020. As of M3 2022/23, the Trust's Capital service capacity is -0.16 , this highlights that the Trust has a deficit position and is unable to cover its financial obligations within a deficit plan of £1.6m.
Income & Expenditure Margin - The income and expenditure surplus or deficit, divided by total revenue.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital -0.85% (February 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		As at M3 2022/23, the Trust's I&E Margin is -5.77% which means that the position is slightly worse than the Trust control deficit.
Liquidity (Days) - Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital -66.53 (February 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		The Trust liquidity days are 5.20 as of M3 2022/23. This is positive and means that the Trust can promptly pay suppliers. As at M3, the cumulative Trust performance against the Better Practice Payment Code was 92%.

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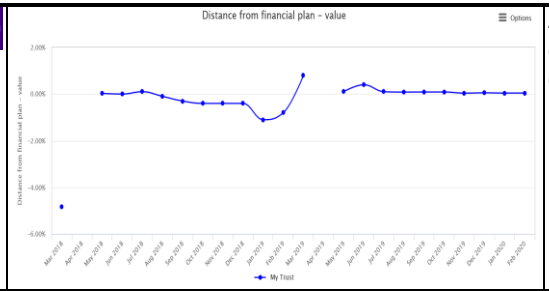
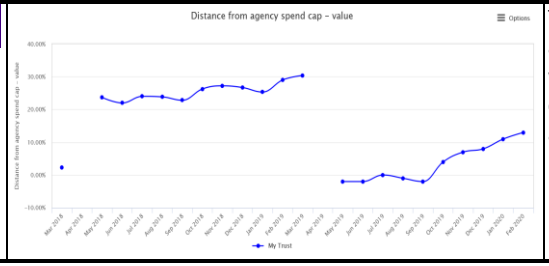
Use of Resources Assessment Dashboard - Q1 2022/23

Action/ Recommendation	Benchmarking/Progress	Trend	Narrative - Warranted/Unwarranted & Justifiable
Distance from Financial Plan - Year-to-date actual I&E margin in comparison to year-to-date plan I&E margin. I&E margin calculated on a control total basis. Measure is in percentage points.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital 0.04% (February 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		As at M3 the Trust is -0.25% from plan. Non achievement of ERF and an increase in drug costs are being partially offset by CIP and slippage in business case developments.
Agency Spend - Cap Value - The extent to which the trust is meeting the target for the amount spend on agency workers for the financial year.	National Median: N/A Peer Median: N/A Best Quartile: N/A WHH Model Hospital 13.00% (February 2020) **Monitoring: FSC/ Trust Board** **Source: Provider Returns**		The Trust continues to closely monitor agency spending for both business as usual and COVID-19 requirements. The agency costs are £1.2m in M3 and £3.7m YTD of which £0.2m related to COVID-19 in 2022/23. In 2022/23 the People Directorate will continue to work with operational teams to reduce the use of agency staffing where appropriate.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q1 2022/23

KLOE/Area	Action Lead(s)	Action Plan
Clinical/ Operational - Operational Efficiency	**Zoe Harris, Director of Operations & Performance**	• Progression of collaboration opportunities through mutual aid/SLAs to maximise use of assets. • Virtual Enhanced Care – review and re-design of processes to improve patient care/experience. Expansion of the use of virtual clinics both within outpatients and inpatient virtual wards. Virtual Frailty is currently being developed and anticipated to be delivered in Q4 2022/23. • Same Day Emergency Care development (SDEC) is to Open July 2022. This will support improvements in patient flow. • COVID-19 Elective Recovery – delivery of the recovery programme for the Trust to achieve the elective activity plan for 2022/23. • DNA - Patient Initiated follow up is live in the majority of specialties. Further actions are to be identified to improve the DNA rate. The Access Policy is currently being reviewed. The Trust is currently reviewing clinic utilisation and hospital initiated clinic cancellations. • The Operational Services are developing and delivering CIP schemes for 2022/23. • Theatre Productivity – review of utilisation including the number of cases per session in Q2 2022/23. • Length of Stay - reduction of length of stay and minimising ward moves. This will support delivery of the 2022/23 activity plan.
People - Sickness	**Carl Roberts, Associate Chief People Officer**	• Establishment of a Supporting Attendance Task and Finish Group which first met in December 2021 with a continued focus on employee Health and Wellbeing. • Focus on interventions for staff living in Halton and Warrington, working with local community partners. • The HR Business Partner Team is providing ongoing support to operational managers in managing sickness absence. This includes advisory support in relation to policy and attendance, welfare, and sickness stage meetings/hearings. • The HR team is working with the Christie NHS Foundation Trust to understand their Welcome Back processes. Alongside this review, the HR team continues to support CBUs through bespoke Welcome Back training, which has had a positive impact on Welcome Back compliance. This training has been incorporated into the new line manager training programme launched in Q1 2022/23 (Bitsized version) which will then be developed into a full line management programme in Q2 2022/23. • Delivery of a Supporting Attendance roadshow via face to face and virtual drop in sessions which all line managers have been invited to. This is an opportunity for line managers to ask questions and gain advice with FAQs developed - sessions will continue to be offered during Q2 2022/23. • Benchmarking work with NHSEI continues with key stakeholders across the People Directorate and included in a range a regional working groups to enable a best practice sharing collaboration.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q1 2022/23

KLOE/Area	Action Lead(s)	Action Plan
People - Retention	**Carl Roberts, Associate Chief People Officer**	• A line manager development programme is being implemented. Implementation of a career development programme is being rolled out Trustwide. The new line manager programme is nearing completion with an anticipated launch date in Q2 2022/23. • Work with NHSE/I "Flex for the Future" programme to look at how we can improve both agile and flexible working throughout the organisation is underway. The Trust has established an agile working group which is developing a set of agile working principles which can be accessed by staff across the Trust. • Team development offers includes; bringing teams back together, leadership offers, and leadership circles. The identification and implementation of a Talent Management framework for WHH, which will be "Scope for Growth" the NHSE/I Talent management approach. • A staff facilities task and finish group has been established to review the current staff facilities based national recommendations and to develop a strategic plan to improve.
People - Staff Costs per WAU	**Carl Roberts, Associate Chief People Officer**	**Staff Costs per WAU:** • The workforce review group Terms of Reference will be reviewed to include the assessment of high vacancies/high temporary staffing spend and will develop action plans to address. • Expansion of the International Recruitment Programme to cover Medics, AHPs, Operating Department Practitioners - no further opportunities have been identified at this time, however the Trust has approved a business case for an additional 30 international nurses for 2022/23.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q1 2022/23

KLOE/Area	Action Lead(s)	Action Plan
Clinical Support - Pharmacy	**Diane Matthew, Chief Pharmacist**	**Savings on Medicines:** A continued focus on Homecare services and Biosimilar switching as opportunities arise. **Job Planning:** Undertake internal review of job plans within the pharmacy establishment. The Trust is going through a procurement process and the Pharmacy Team is awaiting an allocation of system licences in order to progress. **GP Connect:** Implementation of GP connect, enabling the Trust to see a list of medications prescribed by the GP which links into the Trust EPR, reducing the risk of selection errors when prescribing medication in hospital which also improves safety. Anticipated implementation by Q2 2022/23 providing suppliers have addressed outstanding issues. The HTML version of GP connect went live June 2022. **TCAM:** Transfer of medication prescription details to a patients nominated community pharmacy to inform of discharge prescription details. There is a 2022/23 CQUIN around the implementation of TCAM. **ePMA 1 & 2:** The Trust continues to implement ePMA with the last speciality (Neonatal) scoped and signed off in June 2022. A list of equipment has been confirmed with a proposed go live date of October 2022. **ePMA Part 3:** Dose Range Checking - Testing and planning of rollout is anticipated by the end of Q2 2022/23. **ePMA: Part 4:** Integration with JAC system (Stock Control) upgrade released in 2021/22 and progression of testing is underway, there has been some delays in the Trust gaining access to the test system around integration. Therefore it is anticipated that the testing will be completed by Q3 2022/23 (delayed due to a fault found during testing). Part 4 provides some functionality to digitize the supply side of medicines, however full close loop is not available (ability to see ward stock levels and warn when stock levels need to be replenished). **Clinical Research Network:** Halton Clinical Trials Unit is functioning, and the recruitment in to pharmacy posts is progressing • A new pharmacy robot on the Halton site and a replacement pharmacy robot on the Warrington site in order to improve efficiencies and reduce waste - this is included on the 2022/23 Capital programme. The timeframes include identifying a supplier in Q2 2022/23 with implementation in Q3/4 2022/23. • The Trust has approved a Business Case for Pharmacy Phase 2 7 day working within ED in order to bring medicines reconciliation closer to beginning of the patient's pathway. The Trust is in the process of recruiting to these posts. This will improve medicines reconciliation earlier in the inpatient episode which will also improve safety. • Medicines optimisation: A new project in conjunction with the medical director with initial meetings taking place.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q1 2022/23

KLOE/Area	Action Lead(s)	Action Plan
Clinical Support - Radiology	**Mark Jones**	**Radiology Efficiencies:** • The Trust has installed a new MRI machine which will mean the Trust is able to repatriate cardiac MRI and reduce the use of outsourced mobile MRI from August 2022. • Cheshire & Mersey ICS is carrying out a review of how data is recorded and reported across the network to ensure like for like comparisons. This has been paused due to COVID-19. • The department will continue to keep reporting outsourcing at zero. • The Trust is investing in replacing the Cardiac Cath Lab equipment - completed in June 2022 and the Fluoroscopy completed in June 2022 which will support a small increase in capacity. • The Trust was successful in an expression of interest to become a Community Diagnostic Centre (CDC), the business case approved in principle by the Trust Board. This is awaiting national approval. • The Trust is providing mutual aid the in the form of Dexa Scanning to Alder Hey NHS Trust - went live in June 2022. • The Trust is working towards Radiology Accreditation (Quality Standards in Imaging) - due for completion in 2023/24.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q1 2022/23

KLOE/Area	Action Lead(s)	Action Plan
Clinical Support - Pathology	**Neil Gaskell, Pathology Services Manager**	**Pathology Network:** The Trust continues to work with the Pathology Network and specifically with STHK around the future of pathology services across Cheshire & Mersey. A number of options are being explored. A second review of the PID (WHH & STHK) has taken place and the Trust has fed back and is awaiting a response. A number of risks have been identified around Finance, Logistics and Operations. Further detail has been requested from the Network to understand how these risks can be mitigated. A post has been created to support the collaborative work between STHK and WHH with a longer term strategy across C&M, the post has now been recruited to. The Manchester Transformation Unit has been commissioned to write a business case for the Cheshire & Mersey Pathology Network to be complete by Q2/3 2022/23. **Digital Pathology:** The Pathology Network has funded the implementation of a digital pathology solution that allows the scanning and visualisation of microscopic tissue slides for diagnosis. The solution works similarly to tried and tested PACS technology. The network is looking at using a single LIMS supplier in C&M in 2024/25. WHH received £800k in March 2022 for digital capacity for Pathology and Radiology. **Pathology Efficiency & Quality:** • The Trust will pilot the phlebotomy and transfusion application, this will improve patient safety by taking the sample at bedside using the electronic identification system which matches the patient request to the wrist band reducing the risk of taking the wrong blood from the wrong patient and therefore issuing the wrong results. Future options around efficiencies relating to the Phlebotomy application will be explored. The phlebotomy application is being utilised in Outpatients, further work is taking place. This will be followed by Halton, Community services and Wards. Following on from the outpatient pilot a number of changes to the application are taking place to improve usability, a new version of the application has been released which can be utlised over 3/4g with appropriate security measures. • The Pathology Team will carry out a review of cost per test and benchmark against the actual costs in Q3 2022/23. • The Trust has engaged with suppliers and Halton PLACE to electronically book patient appointments for Phlebotomy which will reduce paper and improve patient experience and referrals. A project manager has been assigned with monthly project meetings in place. This is part of the Trust's Digital Operational Group's agenda. Funding has been identified from the ICB and project management support will be provided by Digital Services. • E-Task management system – the Trust utilises its e task management system out of hours to inform acute clinical areas of critical abnormal pathology results. This utilises an interface between the Trust pathology systems and e-task management providing real-time alerts which improves efficiency and patient safety. Currently this is only used in Acute services out of hours, however future options to expand in other areas (excluding A&E and Maternity). The Trust is awaiting suppliers to complete development work in Q2 2022/23 prior to a future rollout. Expected to go live in Q2 2022/23. • Demand Management - removal of Vitamin D testing (where clinically appropriate) at a saving of between £30k - £40k, Intelligent Liver Function Test (iLFT) - reduction of referrals into secondary care by using diagnostics tests utlising a algorithm with a recommended pathway. • The pathology team is exploring opportunities to provide pathology services to third sector and private organisations in order to generate additional income. • The network is looking at a programme of repatriating tests which are completed outside of Cheshire & Mersey where there is a case to do so based on the grounds of costs, quality and use of NPEX for improved turn around times.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q1 2022/23

KLOE/Area	Action Lead(s)	Action Plan
Corporate - Estates	**Ian Wright, Associate Director of Estates & Facilities**	**Strategic Cost Reduction:** • Explore and develop further collaboration opportunities (impacted by COVID-19). The Trust has been engaging in the development of the ICS Estates Strategy. • Review of Facilities Management Contracts at C&M Level (Energy, Linen, Post and Decontamination). A plan has been developed for a collaborative approach across C&M as current contracts expire. There are opportunities to tender collaboratively to reduce costs. • Progression/Expansion of agile working to reduce floor space (this has been accelerated by COVID-19, however due to social distancing requirements, the ability to remove desks has been affected). The Estates & Facilities Team is supporting the agile working group. **Energy Saving Schemes:** • Internal replacement of emergency lighting to improve efficiency is an ongoing programme within capital developments. • Capital spend on projects that will reduce critical infrastructure risk and long term estates maintenance costs. **Collaboration & Sustainability:** • Continued monitoring of critical infrastructure risk and how this has had an impact on estates maintenance costs. • The Trust is looking at employing an Energy & Environment Manager who will be developing decarbonisation plans.
Corporate - Procurement	**Alison Parker, Associate Director of Procurement**	**Procurement Efficiency** • Development of a high-level ICS Procurement Plan to deliver actions with the Procurement Target Operating Model (PTOM) steering group. The Trust is part of a C&M Metrics Group which collectively agreed on the submission at C&M Level (monthly). Progress is measured against a 34 point action plan. The action plan has various dimensions that are expected to be delivered against. PTOM dimension groups have been established. The Trust's Associate Director of Procurement is heading up the data analytics dimension. The data analytics dimension will include a review of catalogue demand across the ICS, tail end spend across the ICS (anything under £5k with a supplier), and review High Cost Excluded Tariff Devices to see if there is potential for savings to be realised. • The Trust has developed a savings tracker on behalf of procurement across the ICS - which is reported into Directors of Finance and the existing CAS (Collaboration at Scale Board). • Further work is being undertaken to develop a collaborative contract register. • Re-engage with SBS regarding the implementation of Edge for Health (a cloud based platform which improves efficiency between Trusts and suppliers). This has been placed on hold by SBS, the Trust is awaiting next steps. • Six Monthly Basis - Every six months the top 500 purchased products based on the total spend of the Trust (% Variance for Top 500 Product Metric) will be run comparing the data to the; lowest floor price, C&M Trusts, NHSE/I Peer Group. This will serve two purposes; support the delivery of savings and support work required in line with model hospital requirements. Saving opportunities will be reviewed on a monthly basis focusing on those with the highest opportunity until all 500 opportunities have been exhausted. This exercise will then be repeated. • Catalogue Benchmarking - The Trust has 309 catalogues in place covering 42,471 product lines. Catalogue Benchmarking is to be undertaken on a rolling monthly basis comparing our catalogue prices to those prices paid across the NHS. • The ICS is looking at potentially moving all organisations onto one e-tendering/contract management platform, this will allow for sharing of activity and outcomes across the ICS. NHSI's platform (ATAMIS) is currently being reviewed with a demonstration in July 2022**.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Use of Resources Assessment - Action Plan Q1 2022/23

KLOE/Area	Action Lead(s)	Action Plan
Finance	**Jane Hurst, Deputy Chief Finance Officer**	**Financial Planning, Sustainability & Controls:** • The Trust will continue to monitor and assess emerging guidance to ensure compliance. Financial performance is closely monitored and variation from plan is addressed in a timely manner. • Continued scrutiny and governance on capital schemes over £0.5m. • The Trust has worked with the system to agree a control total of £6.1m deficit for 2022/23. • Support the development of CIP schemes in 2022/23 and monitoring of Quality Impact Assessments. A new approach to CIP and GIRFT has been agreed with leadership from the Medical Director. • Analysis of corporate benchmarking data to identify opportunities for efficiencies. • Quarterly monitoring of benefits realisation of investments. • Increase scrutiny and governance over retrospective waivers. • Action plan to achieve level 3 Future Focused Finance accreditation. Recommendation made to the national team to award level 3, the Trust is awaiting formal national approval. • Ringfenced cash to support the EPCMS (Electronic Patient Care Management System). The Trust is working with the regional and national team to secure further funding. • Development of an updated Financial Strategy to support the delivery of financial sustainability, approved by the Trust Board in May 2022. • The Trust is working with the ICB (replacing CCGs from 1 July 2022) to agree the 2022/23 contract.

Appendix 3: Corporate Benchmarking by Function/Sub-Function

1. Finance

Finance costs – overall cost per £100m income is at the same level as the ICS lower quartile, however there are some opportunities in relation to the national lower quartile. The finance team has identified 4 sub functions within the finance function where there are potential opportunities for efficiencies.

Finance specific IT systems and ledger – There has been a reduction in cost per £100m income from £135k in 2018/19 to £113k 2020/21 which is due to the increase in income between the financial years. The main cost relates to the service received from SBS. SBS is used by a number of other organisations, however, the data does reflect a similar level of cost per £100m income. Further investigative work is required to understand the costs and how other organisations are allocating the costs in the benchmarking data.

Capital Accounting – There has been an increase of £7k cost per £100m income to £27k in 2020/21. This is reflective of the increase in the capital budget and the increased number of schemes required to be managed compared to 2018/19. Initial review of the capital processes indicates that there may be some efficiencies through change in processes, use of automation or an alternative capital management system.

Income & Contracting – For Income & Contracting there has been a decrease in costs from £105k to £74k in 2020/21. The Trust is now below the national median; however, the Trust is above the ICS median. A further review will be undertaken once new contracting arrangements are known.

Costing – Costs for costing have decreased from £48k to £42k in 2020/21, however, the Trust remains above the national median.

The income and contracting functions are in an integrated team that supports Trust business cases, providing data relating to income, model hospital, patient level costs, and reference cost and market share. The Trust has continued to work on Service Line Reporting (SLR) and is focusing on working with clinicians on costs and pathways. The costing system is being utilised by our clinical services and we have good support and engagement. There is an increased focus on GIRFT and the costing data will drive this agenda to support sustainability. This is an area where investment may be targeted to support delivery of efficiency and productivity opportunities.

See **Table 1** for detail of actions and progress.

Table 1: Finance Sub Function Actions and Update

Sub Function	Action	Owner	Progress to date – Month 3
Finance specific IT systems and ledger	Review of SBS Contract to understand what is included / not. Compare with other organisations	Alice Forkgen	• Established SBS costs has not been allocated out to other areas such as procurement – this has now been reflected for the 2021/22 benchmarking exercise. • Meeting to take place with SBS in Mid-July to improve service received and comparison to contract.
Capital Accounting	Review of current processes and systems Market test – capital systems	Alice Forkgen	• Met with procurement to improve current process • Contacted several organisations to established which system they use for management of capital and identify benefits of a different system
Income & Contracting	Review of current allocations with regards to Strategy work.	Janet Parker	• Reviewed allocations based on actual work for the 2021/22 benchmarking return in July
Costing	Review of additional GIRFT/benchmarking/CIP work which is additional to costing and supported by the Senior Costing Accountant.	Janet Parker	• Given the 2022/23 efficiency target the GIRFT work is more critical than ever. Support to GIRFT to be identified.

2. Governance & Risk

Overall cost per £100m income is at the same level as the ICS lower quartile, however there are some opportunities in relation to the national lower quartile. Clinical Governance, Risk Management Services, Clinical Audit and Corporate Governance all appear to have opportunities when compared to national lower quartile. Further review is required by the team.

3. HR

Overall function cost per £100m is comparable to the ICS lower quartile and the national median. When comparing the 12 sub functions to national and peer medians, the Trust is deemed as better value in 7 of the sub functions. **Table 2** demonstrates the 5 sub functions where the Trust benchmarks worse value than national and peer medians.

Table 2: HR Sub Function Review

Sub Function	Narrative
Non-clinical occupational health and wellbeing	In the highest 25%, quartile 4 – related to the investment within the OH function to support with the response to COVID-19. Where many Trusts relied on national systems and PCR centres – WHH embedded a COVID-19 Call Centre, which enabled the Trust to be reactive to national changes (which there were and still are many), support anxious staff, support COVID-19 breakouts and safely support the redeployment or early return of staff into the workplace. Recognising the importance of this function, both an external review has been undertaken and a Business Case has been approved to permanently recruit into several supportive roles. The service continues to support the organisation, in line with the Supporting Attendance approach to improving the Health and Wellbeing of WHH Employees, thus reducing sickness. Their reputation improves internally and externally, which has supported two Service Level Agreements being agreed with external providers producing a small amount of income. **We believe this expense is warranted variation as the COVID-19 Call Centre supported the organisation with COVID-19 absences**
Workforce information and analytics	In quartile 3 and scoring better value than our peer median – Model Hospital. Throughout 2020/21 this team have supported SLAs with NWAS and Bridgewater to provide services to support their training reporting requirements due to the expertise within this team. The importance of evidence-based decisions has been emphasised by the National NHS People team and with the expertise of the Workforce Information and Analytics teams they have developed dashboards to ensure Workforce Information is accessible to all our managers, providing them with the evidence to justify their decisions. The team has also been a vital support with all the additional reporting requirements COVID required, and until recently, this team operated a 7-day service, to support with these requirements. Having received feedback from local Trusts, the service provided by this team is of the highest quality and seemingly better value than the Trusts peers. **We believe this expense is warranted variation as we offered an exceptional service and were able to respond to COVID-19 data requests**

Education sub-function	Both subfunctions are in quartile 3 and in terms of value, where the most savings could be achieved, however the education of staff is a priority of the Trust since the move to Teaching Hospital status. The Education Sub Function also includes Medical Education and Clinical Education. Recognising the national skills shortages and the level of vacancies with the Trust, the Trust is actively trying to take some ownership. Both Teams are vital to supporting our Clinical Workforce, which includes our international employees and the development of our existing staff into Registered Nursing roles, Consultants via the Caesar route or into other Clinical roles.
Organisational development sub-function	Organisational Development and Education both play important roles in developing and supporting staff, which has been recognised as important as ever, following the previous two years. The organisational development team has a vast range of offers that are available for teams which include the Affina based approach, bespoke TEAMS sessions, implementation of leadership circles for peer support and targeted leadership programmes. 163 bespoke requests were supported in 2021/22 and the offer continues to grow with uptake increasing further in 2022/23. **We believe this is warranted variation as development of new roles/staff is a priority by the Trust. Support for international recruitment also falls within this team.** **Further action:** • **To review to development courses offered, ensuring they are still required and well attended.** • **To review the number of clinical student placements, increasing/decreasing numbers would result in changes to the required educational establishment.**
HR specific systems and licences	The Trust takes advantage of the free systems offered to the NHS, and rather than pay for external systems, either seeks to develop its own or spend time to develop our skills on the free systems. This is true of the Recruitment system (NHS Jobs), Training and Development systems (OLM) and systems relating to HR Case Management, Absence Management and Workforce Information (ESR and In House systems). Where national systems are not available the Trust uses Frameworks to tender for Workforce related systems, these include Roster systems, temporary staffing booking systems, job planning and occupational health. In the case of temporary staffing booking systems, the Trust has tendered with other local Trusts to seek best value for money.

	The Trust is in quartile 3 for the sub function, with the rostering systems making up 60% of the overall spend. There is a national directive that all Trusts should be embedding rostering systems. The majority of our system contracts (including the roster systems) expire on 01/08/25. **Action:** • **To work with procurement, where possible to mirror C&M tendering processes to secure best value for money when signing new contracts for systems.**

4. Payroll

Overall cost per £100m is at the ICS lower quartile and the national median, however, there are still some opportunities when comparing sub-functions to the national lower quartile.

5. IM&T

Overall cost per £100m is better than both the ICS and the national lower quartiles. There are some opportunities when comparing sub-functions, in particular within Paper Medical Records, Clinical Coding, Applications Purchase/Management and Information Services.

Clinical Coding – The Trust is above the national and peer median. The Trust is still largely reliant on paper records which increases the time taken to code clinical records. In addition, due to the national shortage of qualified coding staff, the Trust has a large number of trainees, which require significant resource to train and develop for which the Trust has to invest. The Trust's Clinical Coding Training Manager carries out in house training (which has eliminated all mandatory training costs) and one to one support, with training offered to other organisations which generates income. The team relies on overtime to ensure flex and freeze deadlines are met. The best quartile is mainly made up of mental health and community Trusts which do not have the complexities in coding as acute Trusts. The Trust continues to be in the top quartiles for quality of clinically coded data (GIRFT measures) and the depth of coding is one of the highest when measured nationally and against peer Trusts in Model Hospital. This is a testament to the robust structure of the service with built in audit, training and clinical engagement resources which has contributed to the improvements made over the last 6 years.

The Trust is looking to move to a new EPR in the next few years and coupled with the trainees being fully trained at this stage a strategy will be developed to incorporate a review of costs compared to other organisations. In the short term a review of other trusts in the top quartile for quality and depth will be undertaken to assess whether costs are comparable. Therefore, warranted variation to be reviewed once the new EPR is implemented.

6. Procurement

Overall cost per £100m is above the ICS and national median. Therefore, there are a number of potential opportunities when compared to the national and ICS lower quartile. In particular Receipt and Distribution.

The Associate Director of Procurement is undertaking a deep dive in July and will be presenting the results at the Use of Resources meeting in August.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/07/93**	
SUBJECT:	**Anchor Institution Update**	
DATE OF MEETING:	27th July 2022	
AUTHOR(S):	Kelly Jones, Head of Strategy and Partnerships	
EXECUTIVE DIRECTOR SPONSOR:	Lucy Gardner, Director of Strategy & Partnerships	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#224** Failure to meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience. **#1273** Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely. **#115** Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment. **#134** Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern. **#1125** Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance **#1233** Failure to review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed caused by CAU being bedded and overcrowding in ED resulting in poor patient experience, delays in treating patients and increased admission to the surgical bed base. **#145** Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. **#125** Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.	

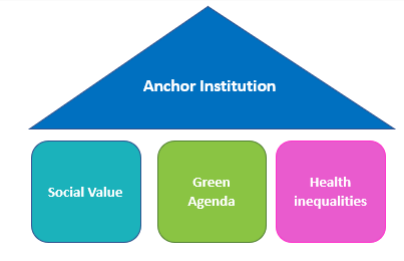
EXECUTIVE SUMMARY ***(KEY ISSUES):***	The Trust is committed to being an anchor institution. In June 2021 a presentation was shared with Trust Board detailing expectations of an anchor institution and providing a baseline assessment of our activities and gaps against the expectations. An update was then provided in November 2021 detailing progress, governance and next steps in the 3 domains within anchor; social value, health inequalities and green. The Trust's anchor programme has been recognised as exemplary both within Cheshire and Merseyside and nationally. The presentation included provides a summary of progress since November 2021 and progress against additional priorities agreed at Trust Board in January 2022. It also outlines proposed future governance of the programme.			
PURPOSE: ***(please select as appropriate)***	Information	Approval	To note x	Decision
RECOMMENDATION:	The Trust Board is asked to support the proposed approach to the refresh of the Trust's 5 year strategy.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.			

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Anchor Institution Update

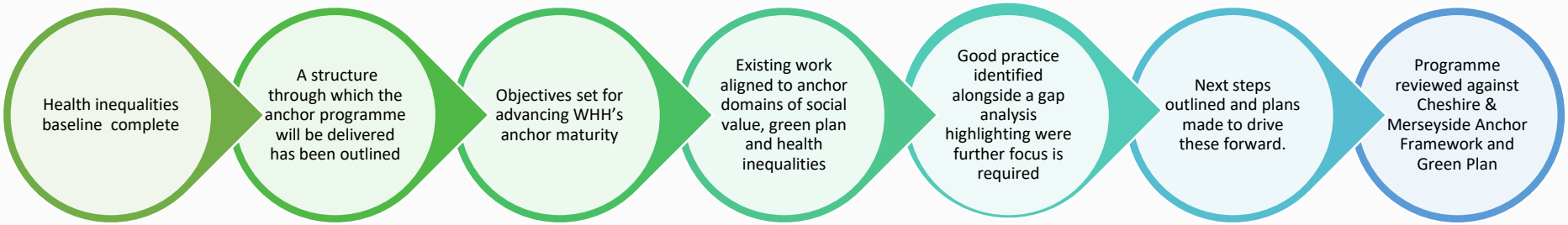
Lucy Gardner, Director of Strategy and Partnerships

July 2022



1. Context

- This document provides a progress update as WHH continues to mature as an anchor institution and advance the Trust's commitment to tackling health inequalities, whilst striving to achieve the NHS Green Plan objectives and boosting opportunities to make a positive social impact.
- Included within the update is an overview of progress made against key next steps as outlined in the January 2021 Trust Board update, and an overview of wider system developments.
- A recap of work completed so far is outlined below.



2. Existing areas of focus

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Social Value

- Developing an Institute of Technology
- Patient Experience and Inclusion Calendar
- Carer Café
- Warrington Public Sector Estates Review
- Warrington Health & Social Care Academy
- Halton Elective Hub
- Central 6 Masterplan
- Implementation of ethical procurement standards
- Supporting Warrington and Halton's Health & Wellbeing Strategies
- Academic Collaboration (University of Chester)
- Developing a value maximisation plan for WHH estate
- Hospice Partnership work – St Rocco's
- Influencing underlying causes of crime to reduce hospital admissions
- Implementing WHH Charity Strategy
- Progressing WHH as an employer of choice

Green Agenda

As detailed within the Green Plan

Health inequalities

- Warrington Town Deal Health and Wellbeing Hub
- Runcorn Shopping City
- Runcorn Town Deal
- Diabetes Prevention
- Prevention Pledge
- Carers Strategy
- First 1,000 days
- Implementing the Prevention Concordat for Better Mental Health for All
- Alcohol related mortality and underlying causes of alcohol related harms
- Childhood Obesity

The existing programme of opportunities continue to be progressed and are reported through the bi-monthly Strategy Report and/or project specific governance routes.

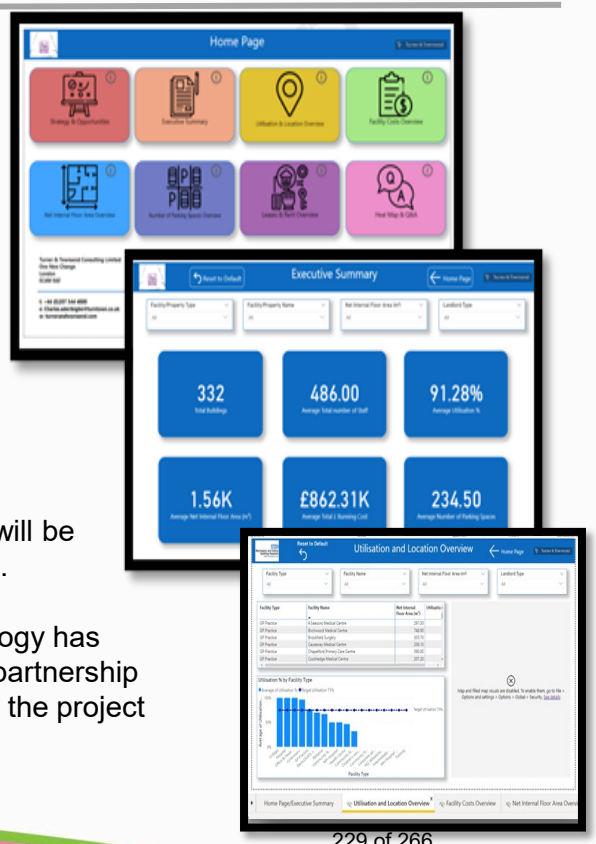
3. Progress highlights

Warrington Wider Estates Review
Was due April 22 and has been completed.

- In collaboration with place partners, a review of the wider estates landscape across the Warrington region has been completed. The review has identified opportunities to maximise the value of collective public sector estate and, for the first time, provides a consolidated view of public sector estate through a single estates asset map which captures: -
  - Utilisation and Space Overview
  - Strategy and Opportunities
  - Facility Costs Overview
  - Net Internal Floor Area Overview
  - Number of Car Spaces
  - Lease and Rent Overview
  - Heat Map and Q&A

.

- Work is now underway with place partners to agree how opportunities will be progressed and how the asset map is used to inform strategic planning.



Institute of Technology Bid
Timeline still emerging

- Cheshire and Warrington's bid to be designated an Institute of Technology has been successful and funding awarded. Work is underway to formalise partnership arrangements and agree next steps. Although, rising costs are a risk to the project and this is under review.

4. Progress highlights

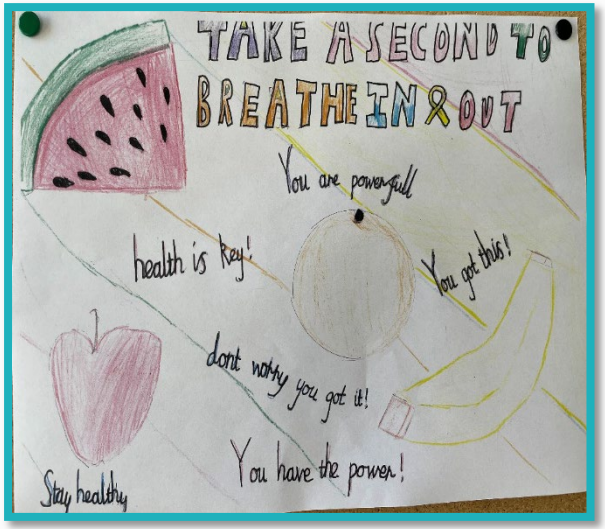
NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Runcorn Shopping City
Completion due September 2022

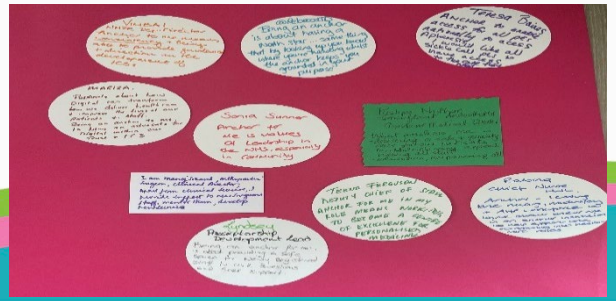
- The Runcorn Shopping City Programme aims to utilise void space in Runcorn Shopping City to deliver health and wellbeing services closer to communities.
- Local schools were invited to design posters that will form the privacy screen on the windows to the front of the unit.
- This has provided an opportunity to get young children and their families thinking about healthy lifestyle choices, whilst raising awareness of intentions to better met local health needs.
- The children participated with enthusiasm and the posters are outstanding.

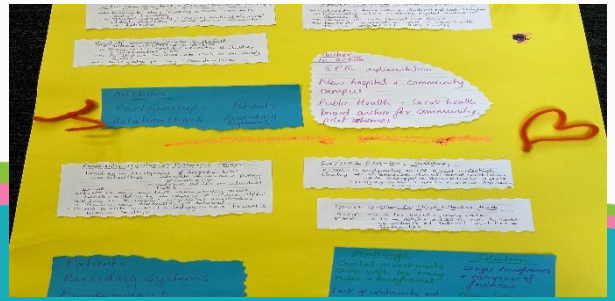
Sharing our best practice at National Conference

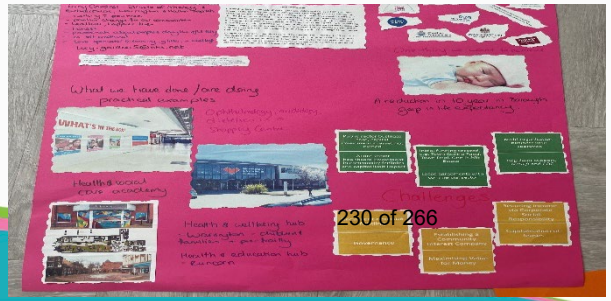
- The Trust was invited to speak at a national conference to share examples of our anchor work.
- This provided a wide reaching platform to share work underway and learn from others.



Poster designed for Shopping City







5. Progress highlights - Warrington Town Deal Health and Wellbeing Hub

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Edith has been invited to the Hub for a routine appointment with an eye clinic liaison officer.

She arrives early so decides to have a coffee in the refreshment area beforehand

Whilst having a drink she gets chatting to a volunteer and explains that she has recently lost her husband

Edith has her appointment upstairs in Clinic Room 1

Afterwards, Edith is offered an appointment with a Wellbeing Worker

Edith agrees and an assessment of her needs is made by the Wellbeing Team

Edith had noticed the Bereavement café advertised and attends on another occasion

As she had started to feel isolated, the Wellbeing worker refers Edith to a local gardening club

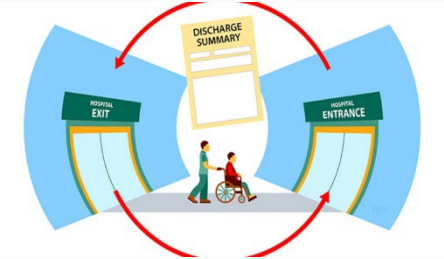
Edith also attends the Library's IT support to help become computer literate

Prevention & mental health offer run throughout. ***Made possible by a Place focus on prevention***

6. Progress highlights

Warrington and Halton Teaching Hospitals NHS Foundation Trust

The Trust's work as an anchor institution is beginning to embed across all parts of the organisation. Below is a showcase of developments which highlight demonstrable impact against our anchor objectives.



Introduction of a ward based Wellbeing advisor to support discharge.

Day one of this post saw an incredibly complicated discharge of a homeless patient facilitated with potential readmission being prevented.

Ensuring disadvantaged groups are offered the opportunity to develop new skills and gain meaningful employment.

The Trust has partnered with Willow Green College in Warrington and Project Search to build a bespoke Supported Internship Programme at WHH for students with disabilities. Designed for people aged 16 to 24 who want to work towards employment but need support to do so. It helps young people achieve their ambitions by offering them work skills/experience within a practical, skills based programme

Falls prevention

Not all people look like a falls risk, not all people will admit they are a falls risk, not all people will understand they are a falls risk.

Following the 2021 Falls Collaborative, we have now introduced a specific Falls Change Package to communicate and explain to the patient and their family that they are a falls risk, educate them to help keep them safe and enable staff to do their utmost to prevent falls, as they can be life-changing events.

7. Progress highlights

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

As a healthcare provider we have a responsibility to promote healthy lifestyles and to reduce the risk of early ill health and diseases. This spans patients and staff. Below are examples of initiatives aimed at prevention.

Covid Vaccination

The Trust continues to provide a Covid vaccination to staff and the public, providing specific tailored support and promotion to the most vulnerable in our communities.

Staff wellbeing

Various initiatives are being promoted to support the mental and physical health of staff, many of which are achieved in collaboration with partners.

8. Progress highlights: NHS Prevention Pledge

Warrington and Halton Teaching Hospitals NHS Foundation Trust

The NHS Prevention Pledge, commissioned by the Cheshire and Merseyside Health and Care Partnership (HCP) through the Champs Public Health Collaborative, encourages NHS Provider Trusts to shift from treating illness to adopting a disease prevention approach which will reduce the impact of ill health on NHS services in the medium and long term.

WHH has been an early adopter of the Prevention Pledge and this is embedded within the anchor programme. The 13 pledge commitments are included in appendix 1.

Below highlights a couple of examples of work being taken forward.

Pledge 2 - Create the conditions to support service managers and staff teams to take a quality improvement approach to review and transform services to embed prevention.

- Quality Improvement Training now offered at Foundation Level to all new starters.
- QI methodology in line with Kaiser Permanente recommendations.

Pledge 11a. Review food and drink provision in line with Hospital Food Standards and the NHS Standard Contract, to make healthier foods and drinks more available, convenient and affordable and limit access to less healthy foods and drinks such as those high in fat, sugar and/or salt.

- Production of Nutritional Care Strategy outlines a programme to meet the "10 key characteristics of good nutritional care".
- Development of bespoke food offer through new public canteen at Warrington Hospital, enabling access to fresh and healthy meals throughout the day.

9. Areas which have changed focus or are off schedule

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Partnership working with local Hospices
Key objectives and deliverables due to be agreed by Feb 22

- As part of the development of Place-Based integrated care across Warrington the Trust is developing partnerships with other local anchor institutions to support and strengthen core aspects of each organisation's operations and add social value.
- Two of these local anchor institutions are St Rocco's Hospice and Halton Haven Hospice, with whom we are looking at ways to improve communication, pathways, recruitment and staff training/education for end of life services across Warrington and Halton.
- It was originally envisaged this would be through identification of key objectives and implementation of formal action plans. However, a more organic approach is being pursued through a focus on relationship development and connecting agendas, which is leading to improvements. For example links between St Rocco's Chief Operating Officer and senior WHH HR leads have been created to explore potential for WHH to provide occupational health support to the Hospice.
- This direction will continue to be pursued and reviewed as required.

First 1000 days

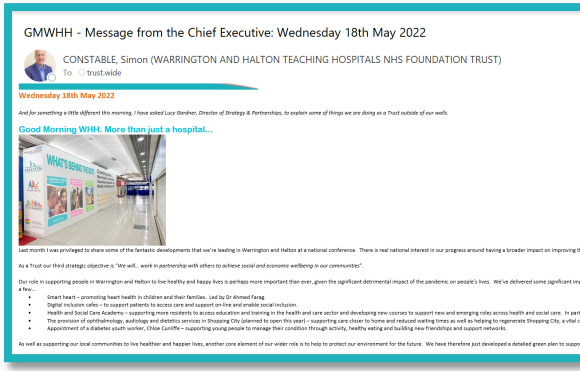
- The Trust is working with Cheshire and Merseyside LMS to incorporate a 'smoke free pregnancy' pathway within the maternity service. This will ensure a consistent approach is given across C&M to reduce smoking during pregnancy in line with Government targets.
- Patient held digital maternity records are now in place.
- Team River within the maternity service are providing targeted support to more vulnerable and disadvantaged women in our communities to enable equity of access and tailored care.
- A full review of work underway across Warrington and Halton, its impact and the remaining gaps in improvements needed is required. Further priorities and actions will then be incorporated into place delivery plans, following the refresh of local Health and Wellbeing strategies.

10. Action against agreed next steps (programme)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Launch Anchor programme to staff
Due May 22

- Internal communications commenced in May 2022 to highlight the Trust's role as an anchor and to showcase the range of work underway. Regular communication aligned to anchor objectives will take place monthly.


GMWHH - Message from the Chief Executive: Wednesday 18th May 2022

CONSTABLE, Simon (WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST)
To trust.wide

Wednesday 18th May 2022

And for something a little different this morning, I have asked Lucy Gardner, Director of Strategy & Partnerships, to explain some of things we are doing as a Trust outside of our walls.

Good Morning WHH. More than just a hospital...

Launch WHH's Green Plan
Due May 22

- The Green Plan was approved by Trust Board in March 2022 and was then shared with staff along with a survey to gauge "What Green means" to our staff. The survey sought to identify how we might harness staff energy to drive the plan forward and what staff perceive as the biggest challenges.
- Insights gathered were used to design a staff engagement approach for those interested in having a broader impact on improving the lives of the communities we serve, over and above our provision of high quality hospital services.

What green means to me

challenges

236 of 266

Work towards targets set within Cheshire & Merseyside Integrated Care System Green Plan 2022

- Review of actions undertaken by Green Plan Action Leads.
- Actions mapped against ICS Green Plan. 41 objectives were already covered and 19 were added.
- Governance in place to monitor and report progress.

11. Action against agreed next steps (programme)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Work towards targets set within Cheshire & Merseyside Integrated Care System Green Plan 2022 *(cont)*

- Navajo Charter Mark achieved.
- The Trust has already attained Disability Level Confident 3 award (standard for ICS is level 1). WHH is the only Trust to achieve level 3 in the country and the 2nd organisation in Warrington (the 1st being Warrington Disability Partnership).
- Work is progressing to incorporate sustainability and social value into all job descriptions from Q4 2022/23.

Develop a simple process to harness the passion of individuals and teams

Due April 22.
Launched July due to operational pressures

- In July 2022, **The Great, Good and Green Forum** was launched. Green Plan action leads and staff known to have an interest in social value and health inequalities were invited to attend. Additionally, an open invitation was circulated to all staff to attend.
- The Forum's purpose is to promote awareness and widespread adoption of the Trust's ambitions as an anchor institution, facilitate open discussion and idea sharing on initiatives to support the Trust as an anchor, and enhance delivery of our Green Plan.
- The Forum will be the vehicle through which staff will be empowered and supported to identify and deliver their own anchor initiatives and where initial guidance and support to enable delivery of initiatives/actions, supporting the Trust as an anchor will be provided.

12. Action against agreed next steps (programme)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Develop an estates maximisation plan
Due Feb 22

Use of Trust Estate as an asset to be used in ways that addresses resource gaps in communities and supports residents to live healthy lives is now a key pillar of the WHH Charity Strategy 2022-25 and will be monitored as part of the strategy's implementation.

Measuring impact
Due April 22

Each key strategic project that tackles health inequalities or seeks to make a positive social impact has mechanisms in place for how impact will be measured. However, in order to evidence and measure the impact of the Anchor Programme in its totality, an overarching framework is required.

Work was paused on development of this framework as it was understood this would be produced by NHS Cheshire & Merseyside (ICS) as part of the Anchor Charter. To date, metrics have not been released, although it is understood they are still within the scope of work.

Consideration has been given to how we should proceed and it is proposed the overarching impact measures for the programme are aligned to the evaluation of Place Health & Wellbeing Strategies. This will enable a consistent view of collective impact across each Place, achieved through standardised metrics across partners. Discussions are scheduled to take this forward.

When metrics are released from for the Anchor Charter, we would still seek to incorporate these if they are not already within the framework.

New Deadline – July 2023

13. Action against agreed next steps (opportunities)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Procurement

• Assess WHH spend on goods and services with SMEs and understand what this is as a % of our total influenceable spend on goods and services by Jan 22.	• Assessment is complete and identified 7% of the Trusts total spend is spread across 1,892 SME's within a 25 mile radius of Warrington Hospital. Understanding the nature, scope, value and impact of local contracts makes for informed discussions regarding balancing the pledge to employ and purchase more locally with the requirements set out in the Public Contract Procurement regulations.
• Implement initiatives from the NW Sustainability Group in terms of single use plastics, recycled goods etc.	• All initiatives implemented.
• Develop a procurement strategy to include approach to sustainability and social value by April 22	• Procurement is currently contained within the Finance Strategy. A commitment has been made to developing an organisational procurement strategy but this has been delayed pending the work underway across Cheshire & Merseyside to develop a regional procurement strategy. It is important the Trust's strategy aligns to and enhances the regional strategy and as such, work will recommence once the C&M strategy is produced.

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14. Action against agreed next steps (opportunities)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Procurement

- Commence work with other anchors to use our procurement and recruitment power to maximise local employment opportunities and maximise wider social value and green opportunities

- Worked with regional partners to develop a Partnership Agreement with NHS Supply Chain. This commenced April 22 and is a 3 year contract.

- New legislative requirements to include a 10% social value assessment within contracts has been utilised to drive social value as highlighted in the contracts below

Contract Title - Provision of Fire Door Inspection and Maintenance (Contract Value £300k); Provision of Hire, Service and Maintenance of Tugs (Contract Value £75k).

Social value extracted by asking suppliers to: -

- Provide evidence they are either accredited by the Living Wage Foundation or a statement that demonstrated they are paying the Real Living Wage to all applicable employees.
- Provide a copy of their Sustainability Policy and describe how they monitor and measure delivery and performance against the objectives set in their Sustainability Policy, inclusive of any targets set.

Example of the principles contained with the NHS Supply Chain Partnership Agreement

Environmental and Social Value Consideration – The Partnership will seek to deliver improved social welfare or wellbeing when carrying out any procurement activity.

Usage and disposal of products – The Partnership will promote the efficient use of products recognising that overall expenditure is significantly influenced by the effective management of demand as much as the purchase price paid.

One of the SMART Objectives:

- To support delivery of the NHS Green Plan by providing evidence based sustainable options where available, including but not limited to; minimisation of waste including packaging and product disposal, maximisation of the reuse and recycling of materials and working with the ICS to develop sustainable performance measures expected from products that can be used in the procurement process

15. Action against agreed next steps (opportunities)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Commence new priority areas - Alcohol

- A collaborative pilot project is underway in Warrington to explore the potential for physical activity to reduce harm from alcohol and improve recovery from alcoholism . Working with community-based providers, the pilot seeks to prevent attendances at A&E and improve patient outcomes by use of social prescribing for physical activity in particular cohorts.
- Support is being given to the Cheshire & Merseyside 'Lower my Drinking' campaign. Messaging is being promoted to staff and patients as part of a coordinated approach.

Commence new priority areas - Respiratory

- A business case is in development to establishment a Quality Assured ARTP (Association for Respiratory Technology & Physiology) Community Diagnostic Spirometry Service across the seven PCN footprints of the combined Places of Warrington and Halton. External funding is secured and, subject to approval, the service will be operational from December 22.
- Explore potential to establish a one stop shop to confirm diagnosis of COPD/review those with suspected COPD/review medications and ensure they're optimised and suitable for current condition. This was piloted previously in Widnes.

16. Cheshire & Merseyside's system approach to anchor institutes and sustainability

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Our Principles as an Anchor System:

- As an Anchor Institution we commit to the real living wage and creating equality within our local job sector.
- We pledge to employ and purchase, locally, in the first instance with an aim to support the wealth of local businesses within our geography.
- We pledge to work closely with partners and, where possible, ensure our buildings are viewed as local, community assets.
- We are committed to measuring and evidencing the progress made as a result of becoming an Anchor Institution.

How this compares against WHH Anchor Programme

- The national living wage, effective from 1 April 2022, is an hourly rate of £9.50 for anyone ages 23 or over. The Real Living Wage is a different rate set by the Living Wage Foundation. The UK Real Living Wage is an hourly rate of £9.90, meaning entry point on Agenda for Change bands 1 & 2 fall below this.
- For WHH this is circa 375 Individuals and would cost circa £130k to increase salaries to £9.90ph. However, this would take these staff outside of Agenda for Change terms and conditions. Work is underway with local payrolls to map approaches and a benchmarking exercise is underway.

- Pledge commitment in place. However, discussions ongoing about how to balance with Public Contracts Procurement Regulations.

- Maximising use of our estate as a community asset and a means of creating social value is a core theme in the recently refreshed Charity Strategy. Warrington wider estates initial review completed.

- Measuring impact through benefits realisation is included within all strategic projects.

17. Cheshire & Merseyside's system approach to anchor institutes and sustainability

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Our Priorities as an Anchor System

- Develop and implement a Net Zero plan, setting out our journey towards zero carbon by 2040 or sooner.
- Our Anchor work is complemented by the Social Value Charter, to provide alignment organisations involved will have achieved, or be willing to achieve, the C&M Social Value Award within six months of signing.
- Anchor organisations will be involved in and sign up to the Cheshire and Merseyside Prevention pledge (currently applicable to Trusts only), driving a population approach to prevention and working alongside the national Core20PLUS5 supporting the efforts to reduce health inequalities.
- Develop an Anchor Network Progression Framework to help organisations self-assess progress/ ambitions as an anchor.

How this compares against WHH Anchor Programme

- ☑ Green Plan approved with key actions set out to deliver zero carbon by 2040.
- ☑ WHH was an early adopter of the Social value Charter and the Trust has been accredited with the Cheshire and Merseyside Social Value Award for our pledge and action to deliver social value in 4 areas:

 Economic  Social  Environmental  Innovation

- ☑ WHH was a pilot site for the Prevention Pledge and is following a structured programme of work that is intended to embed prevention of ill health within core service delivery, whilst enhancing preventative actions with local partners working 'at place'.
- ☑ WHH has clearly articulated ambitions as an anchor, has already assessed progress as an anchor and has objectives in place to grow maturity. The Trust is well positioned to self-assess against the framework.

18. Governance

Action	Delivered by
Incorporating Anchor into Strategy refresh Embedding our anchor ambitions will be further cemented by including them as core features of the Trust wide strategy refresh. Anchor priorities will also be included in Place based delivery plans.	April 2023
Streamlining reporting The scope of the anchor programme is vast. There is a balance to be had between understanding progress and impact, while enabling opportunities to positively influence the health and wellbeing of the patients we serve and the local communities we are part of to happen organically. Reporting against the key strategic projects which constitute the anchor programme will become part of reporting against the Trust's overall strategy	April 2023

Appendix 1
Cheshire & Merseyside Prevention Pledge Commitments

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- 1.Prioritise a long-term focus on well-being, prevention and early intervention ensuring health in all policies; embedding prevention within our governance structures, appointing an Executive Sponsor for prevention (including MECC), and making 'prevention everybody's business'.
- 2.Create the conditions to support service managers and staff teams to take a quality improvement approach to review and transform services to embed prevention.
- 3.Guided by Marmot principles; develop approaches to prevention, working with our partners 'at place', to address inequalities and deliver local priorities and prevention ambitions set out within the NHS Long Term Plan and in COVID recovery plans.
- 4.Work in partnership in the utilisation of common prevention pathways across Trusts, supporting secondary and tertiary prevention that reduces the impact of established disease through lifestyle advice and cardiac or stroke rehabilitation programmes.
- 5. Establish key anchor practices that contribute to a successful application for the Cheshire and Merseyside Social Value Award; to positively impact on the wider determinants of health and the climate 'health' emergency when making decisions on procurement, purchasing and through our organisation's corporate social responsibilities.
- 6. Systematically adopting and embedding a 'MECC approach' from commissioning contracts to service delivery, increasing the number of brief or very brief interventions with patients supporting them to eat well, be physically active, reduce harm from alcohol and tobacco and promote mental well-being.
- 7.Work with primary care, local authorities and VCSO's to systematically refer to sources of non-clinical support through social prescribing, aligned with community capacity building to reduce impact on GP consultation rates, A and E attendance, hospital stays and re-admission, medication use, and social care.
- 8.Support workforce development, providing training and/or resources to frontline staff to offer brief advice and/or referral in supporting patients to eat well, be physically active, reduce harm from tobacco and alcohol and promote mental well-being.
- 9.Ensure a smokefree environment, linked to support to stop smoking for patients and staff who need it.
- 10. Provide workplace health programmes for NHS staff and foster an organisational culture that promotes workplace resilience and creates opportunities for staff to eat well, be active, reduce harm from tobacco and alcohol and promote mental well-being.
- 11a. Review food and drink provision across all our NHS buildings, facilities, and providers in line with Hospital Food Standards and the NHS Standard Contract, to make healthier foods and drinks more available (including vending and onsite catering), convenient and affordable and limit access to less healthy foods and drinks such as those high in fat, sugar and/or salt.
- 11b. Increase public access to fresh drinking water on NHS sites (keeping single use plastics to a minimum) and encouraging re-useable bottle refills.
- 12.Support the sub-regional physical activity strategy; to promote and create opportunities for staff, patients, and visitors to be physically active both on and off site and in line with active travel and sustainable management plans.
- 13.Sign up to the 'Prevention Concordat for Better Mental Health for All' and to embed the Prevention Concordat across health and care policies and practices.
- 14. Monitor the progress of the pledge against all commitments and to publishing the results of our progress at regular intervals.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/22/07/94**			
SUBJECT:	**Trust Strategy Refresh Plan**			
DATE OF MEETING:	27th July 2022			
AUTHOR(S):	Lucy Gardner, Director of Strategy & Partnerships			
EXECUTIVE DIRECTOR SPONSOR:	Lucy Gardner, Director of Strategy & Partnerships			
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	x		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	x		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	x		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	**#145** Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust's 5 year Strategy 2018- 2023 is due to expire in April 2023 and much has changed since it was developed in 2018. The Trust's objectives and associated outcomes and measures of success have been and continue to be regularly refreshed during the 5 year period. However, a full refresh of the Trust's Strategy is proposed to enable a revised strategy to be published in 2023. The presentation sets out the proposed approach to the refresh of the strategy.			
PURPOSE: *(please select as appropriate)*	Information	Approval	To note	Decision x
RECOMMENDATION:	The Trust Board is asked to support the proposed approach to the refresh of the Trust's 5 year strategy.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Executive Team		
	Agenda Ref.			
	Date of meeting	15th July 2022		
	Summary of Outcome	The approach was supported by the Executive Team.		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Strategy Refresh Plan

July 2022

Lucy Gardner
Director of Strategy and Partnerships

1. High level timeline for strategy refresh

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23

Analyse

- Organisational SWOT analysis
- Review of existing goals
- Review of national, regional and place strategies
- Forecast of future considerations

Identify

- Staff and wider stakeholder engagement to inform aims, objectives, outcomes & KPIs
- Define delivery approach

Review

- Review the strategy internally and externally

Agree

- Strategy sign off

2. Analysis phase

Warrington and Halton Teaching Hospitals NHS Foundation Trust

The analysis phase will include the following activities:-

- Review clinical visions and priorities for each speciality
- Review national, regional and local strategies and emerging priorities, including C&M & place partners
- Review existing internal strategies
- Forecast future priorities i.e. Place developments, alignment for new hospital ambitions, role as an anchor
- Review public health data
- Review performance, quality & financial performance
- Review patient experience and complaints to identify priorities
- Review patient feedback more broadly – i.e. commissioner insights, Healthwatch insights, patient council insights
- Review outputs from staff survey

- **Organisational SWOT analysis with Trust senior managers and clinicians (clinical & corporate)**
- **Organisational SWOT analysis with Trust Board**
- **Organisational SWOT analysis with Place Partners – Warrington & Halton separately**

3. Identify phase

The identify phase will include the following activities/meetings/discussion to share emerging themes from the initial analysis phase and to seek further input:-

Staff

- Discussion at Board
- Discussion at Medical cabinet
- Discussion at Care Group/CBU meetings
- Discussion with corporate services
- Staff engagement sessions – market stalls, survey monkey, Grand Round, Team Brief

Delivered through face to face strategy sessions would be preferable

System

Exec-level from:-

- ICB
- Provider collaborative
- Place Boards – Warrington Together Board, One Halton Board

Patients/Public

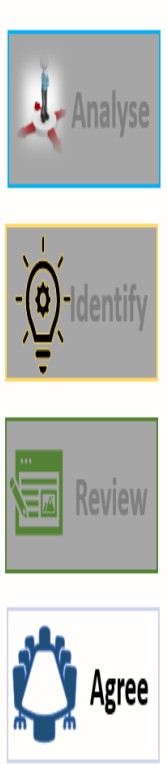
- Engagement with advocates, place representatives and third sector partners
- Engagement with Council of Governors
- Targeted engagement with people and communities, including recruitment of experts by experience

4. Review phase

The review phase will compare and contrast the outputs of the various engagement activities with the original analysis to outline the content of the strategy. This will be followed by a validation exercise that will include, but not be limited to, discussion with the following groups

- Discussion at execs
- Discussion at Board
- Discussion at Care Group/CBU meetings
- Discussion with corporate services
- Discussion with staff
- Discussion with ICB
- Discussion with Provider Collaborative
- Discussion with Place Boards

5. Agree phase



Strategy & A Greener WHH
3-Feb-23

Executive Team
w/c 6-Feb-23

Finance & Sustainability Committee
22-Feb-23

Quality Assurance Committee
7-Mar-23

Strategic People Committee
22-Mar-23

Trust Board
29-Mar-23

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/22/07/95**	
SUBJECT:	**Board Assurance Framework**	
DATE OF MEETING:	27th July 2022	
AUTHOR(S):	John Culshaw, Trust Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Simon Constable, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: **(*Please select as appropriate)***	SO1 We will.. Always put our patients first through high quality, safe care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse, engaged workforce that is fit for the future. SO3 We will ..Work in partnership to design and provide high quality, financially sustainable services.	✓ ✓ ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): **(*Please DELETE as appropriate)***	All	
EXECUTIVE SUMMARY ***(KEY ISSUES):***	It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Assurance Committee. A Risk Review Group has been established reporting to Quality Assurance Committee, for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately. Since the last meeting: • No new risks have been added; • The ratings of two risks have been reduced • The description of four risks on the BAF has been amended and there are proposals to update a further eight risk titles • One risk has been closed and it is proposed to close two further risks Notable updates to existing risks are also included in the paper.	
PURPOSE: ***(please select as appropriate)***	Information	Approval ✓ / To note / Decision
RECOMMENDATION:	The Trust Board is asked to discuss and approve the changes and updates to the Board Assurance Framework.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC 22/07/178
	Date of meeting	05.07.2022
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework and Strategic Risk Register report	AGENDA REF:	BM/22/07/95

1. BACKGROUND/CONTEXT

This is an update of strategic risks on the Trust Strategic Risk Register. It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register, following review at Quality Assurance Committee. A Risk Review Group has been established reporting to Quality Assurance Committee, for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately.

The latest Board Assurance Framework (BAF) is included as Appendix 1.

2. KEY ELEMENTS

2.1 New Risks

Since the last meeting no new risks have been added to the BAF

2.2 Amendment to Risk Ratings

Since the last meeting, and following discussion at the Risk Review Group on 4th July and subsequent approval at the Quality Assurance Committee on 5th July 2022, the ratings of two risks have been reduced.

1. Following a review of **Risk #115** and the additional assurances in place, it was agreed to reduce the rating from 20 to 16

ID	Risk description	Rating (previous)	Rating (current)	Executive Lead
115	Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment.	20	16	Kimberly Salmon-Jamieson

2. As a result of increased collaborative working, it was agreed to reduce the rating of risk **#145** (as detailed below) from **15** to **12**.

ID	Risk description	Rating (previous)	Rating (current)	Executive Lead
145	Influence within Cheshire & Merseyside a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best	15	12	Simon Constabe

	outcome for our patient population and organisation, potential impact on patient care, reputation, and financial position. b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.			

2.3 Amendments to descriptions

Following a review of the descriptors used in the titles of the Trust's risks, the template of the wording of risks is changing from ***Failure to……Caused by……Resulting in…..*** to ***If…….Then…..***

Since the last meeting, the descriptions of **four** risks have been amended and it is proposed to update a further **eight**.

Approved

Following discussion at the Quality Assurance Committee on 5th July 2022, it was agreed to amend the titles of four risks:

1. **Risk #115**

Previous: *Failure to provide minimal staffing levels in some wards and departments. Caused by vacancy position, current sickness levels and absence due to COVID 19. Resulting in depleted staffing levels, potentially impacting the ability to provide basic patient care and treatment*.

Current: *If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.*

2. **Risk #1275**

Previous: *Failure to prevent Nosocomial Infection caused by high transmissibility of variant strains, waning effect of vaccines, asymptomatic carriage (staff or patients), false negative test results, high local community prevalence.*

Current: *If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation.*

3. **Risk #1233**

Previous: *FAILURE TO review surgical patients in a timely manner and provide a suitable environment for surgical patients to be assessed CAUSED BY Combined Assessment Unit (CAU) frequently being bedded with inpatients due to overcrowding in the ED and an excess demand for inpatient beds RESULTING IN a lack of surgical assessment bed capacity, poor patient experience, delays in treating surgical patients and increased admissions to the surgical bed base.*

Current: *If we bed the Combined Assessment Unit (CAU) then we will not have a suitable environment to review surgical patients in a timely manner resulting in a lack of surgical assessment bed capacity, poor patient experience, delays in treating surgical patients and increased admissions to the surgical bed base.*

4. **Risk #145**

Previous: *Influence within Cheshire & Merseyside*

a. Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.

b. Failure to fund two new hospitals may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.

Current: *If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, the then Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.*

Proposed

It is proposed to amend the description of six risks for that have previously been submitted to the appropriate Committee for support.

1. **Risk #224**

Current: *Failure to meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience.*

Proposed: *If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity then the Trust may not meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience.*

2. **Risk #1215**

Current: *Failure to deliver the capacity required caused by the ongoing COVID-19 pandemic and potential environmental constraints resulting in delayed appointments, treatments and potential harm*

Proposed: *If the Trust does not deliver the capacity required because of the ongoing COVID-19 pandemic then there may be delayed appointments, treatments, and potential patient harm.*

3. **Risk #1273**

Current: *Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely.*

Proposed: *If we continue to experience system-wide Covid-19 pressures, then we may be unable to provide timely patient discharge and experience potential reduced capacity to admit patients safely.*

4. **Risk #1289**

Current: *Failure to deliver planned elective procedures caused by the Trust not having sufficient capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm*

Proposed: *If the Trust does not have sufficient capacity (Theatres, Outpatients, Diagnostics), then we may be unable to deliver planned elective procedures, which may cause potential delays to treatment and possible subsequent risk of clinical harm and failure to achieve constitutional standards.*

5. **Risk #134**

Current: *Financial Sustainability*

a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken.

b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that future loans will be required which would raise the question if the Trust is a going concern.

Proposed: *If the Trust is not finacially viable then there may be an impact on patient safety, operational perforamnce, staff morale and potential enforcement/regulatory action taken*

6. **Risk # 1372**

Current: *If the Trust is unable complete a successful EPR strategic procurement project in line with the Trust's time, budget and quality requirements, due to*

- *An inability to develop an affordable business case due to, baseline costs, strong existing benefits & lack of new cash releasing benefits*
- *An inability to garner ICS and NHSE support to progress the EPR business case*
- *An inability to deliver Managed Convergence in line with emergent national policy and the ICS Convergence strategy (currently poorly defined and in development)*

Then the Trust will be unable deliver a future Electronic Patient Record Solution

Resulting in (sequentially)

- *A continuation of the Trust's challenges with the incumbent EPR, Lorenzo (as identified in the Strategic Outline Case)*
- *Potential for a costly extension to the existing Lorenzo contract or the highly retrograde step of returning to paper systems as Lorenzo will be at end of life at (or before) the end of the tactical contract extension*

Proposed: *If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety*

7. **Risk #1134**

Current: *Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain*

Proposed: *If we see an increase in absence relating to COIVD-19, then we may experience resource challenges and an increase within the temporary staffing domain.*

8. **Risk #125**

Current: *Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.*

Proposed: *If the hospital estate is not sufficiently maintained then there may be an increase in capital and backlog costs, a rwduction in compliance and possible patient safety concerns*

2.4 De-escalation of Risks

Since the last meeting, one risk previously on the BAF has been closed and it is proposed to close a further two.

Approved

Following discussion at the Risk Review Group on 4th July 2022, and subsequent approval at the Quality Assurance Committee on 5th July 2022, it was agreed to close **risk #1108** (detailed below) that specifically related to maintaining appropriate staffing levels as a result of COVID-19. The ongoing risks associated with this have been captured in risk #115

ID	Risk description	Rating (current)	Executive Lead
1108	Failure to maintain staffing levels, caused by high sickness and absence, including those affected by COVID-19, those who are assessed as only able to work on a non-respiratory pathway, resulting in inability to fill midwifery shifts. This also currently affects the CBU management team.	16	Kimberly Salmon-Jamieson

Proposed

It is proposed to close **risk #1125** (detailed below) that specifically related to achieving constitutional standards as a direct result of the COVID-19 pandemic and combine the risk with risk #1289 (proposed updated title is described in section 2.3).

ID	Risk description	Rating (current)	Executive Lead
1125	Failure to achieve constitutional access standards caused by the global COVID-19 Pandemic resulting in high attendances and occupancy, non-compliance for RTT, Diagnostics, Cancer and ED Performance	20	Dan Moore

It is proposed to close Risk #1079 (detailed below). This risk is associated with having an EPR which cannot safely and effectively manage the antenatal patient pathway. With the successful implementation of Badgernet – a best in breed, custom antenatal care EPR, this risk has been effectively mitigated with Badgernet being able to capture all the clinical data required, allow robust and accurate documentation and support effective communication, particularly through the medium of electronic patient held antenatal notes. There remains a

lesser risk regarding the interoperability of Badgernet with the native Lorenzo EPR although this is of a lower severity and will feature on the appropriate Departmental or Corporate Risk Register

ID	Risk description	Rating (current)	Executive Lead
1079	If we do not provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes because we have an IT system (Lorenzo) which is not maternity specific and does not have a robust internet connectivity, with inadequate support to cleanse data and no intra-operability between services, then we will be unable to capture all required data accurately, have a robust electronic documentation process in cases of litigation or adverse clinical outcome and poor data quality. In addition, inadequate communication with allied services, such as health visitors will be uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff.	20	Kimberly Salmon-Jamieson

2.5 Existing Risks - Updates

Detailed below are the updates that have been made to the risks since the last meeting.

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
224	Failure to meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches, caused by capacity constraints in the Local Authority, Private Provider and Primary Care capacity resulting in potential risks to the quality of care and safety to patient, staff health and wellbeing, Trust reputation, financial impact and below expected patient experience.	• Same Day Emergency Care Centre (SDEC) planned opening July 2022 • Plans to co-locate ED Minors in the SDEC building to enhance patient pathways being worked up for Winter 2022/23 • Revenue bid submitted to the ICS to open additional urgent care capacity (CAU) over Q3/4 2022/23	25	No impact on risk rating
1273	Failure to provide timely patient discharge caused by system-wide Covid-19 pressures, resulting in potential reduced capacity to admit patients safely.	• System-wide agreement to invest in Dom Care ICHAT & Discharge Team recruitment now underway and set to complete in Q4 2023 • Funding agreed by Warrington Borough Council to keep Lilycross open for 2022/23 • Trust Executive approval to keep Ward B3 open for 2022/23	25	No impact on risk rating
1275	If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors,	<u>Assurances</u> • Triage and testing on emergency admission using molecular and PCR testing.	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation.	• Planned procedure testing SOP • Guidance for staff returning to on-site working (previously considered extremely vulnerable) • Communications through TWSB to staff reinforcing updates to Covid-19 SOPs. • Surveillance of patient in bays for 7 days following Covid-19 exposure. • Risk assessment in place for use of beds in Covid-19 exposed bays to protect immunosuppressed and unvaccinated patients. • Asymptomatic staff testing using Lateral Flow Device testing is encouraged. • IPC Team liaise with Patient Flow Team on patient placement • Updated IPC measures in place including the relaxation of mask wearing in certain areas of the Trust, a return to pre pandemic visiting arrangements and 1 relative/carer to accompany patients in the Emergency Department. • Updates to Trust Guidance/SOPs in line with publication of national guidance and upload to the Hub <u>Gaps</u> • Increased risk from return to pre-pandemic standards with removal of social distancing requirements, removal of universal masking and opening up visiting • Non-compliance with PPE • Site-wide assessment of ventilation (mechanical and manual) – action plan required to ensure all areas with mechanical ventilation are compliant with standards • Unknown uptake of asymptomatic staff testing – LFD testing as this is not centrally reported		
1289	Failure to deliver planned elective procedures caused by the Trust not having sufficient	• Business Case to increase WLI rate approved by the Trust Board in June 2022	20	No impact

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	capacity (Theatres, Outpatients, Diagnostics) resulting in potential delays to treatment and possible subsequent risk of clinical harm	• Appointment of Outpatient transformation role in July 2022 to support increased efficiency and effectiveness of Outpatients •		on risk rating
134	Financial Sustainability a) Failure to sustain financial viability, caused by internal and external factors, resulted in potential impact to patient safety, staff morale and enforcement/regulatory action being taken. b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that future loans will be required which would raise the question if the Trust is a going concern.	<u>Assurances</u> • Weekly review of financial planning at extended Executive team meeting • Procurement/tender waiver training in place • ICS executive peer to peer review June 2022, next planned at the end of month 6 • Unqualified audit opinion (2021/22) • TIF funding application to support recovery at Halton c£8m over 3 years and also £26.4m bid for a Community Diagnostics Centre (CDC) at Halton • Financial strategy developed to support improvement in financial sustainability. 2022-2027 Financial Strategy approved by the Trust Board in May 2022 <u>Gaps</u> • CIP of 15.7m (£7m identified) • Requirement for £3m additional income and delivery of activity plan to achieve c £8m ERF. • Current financial plan shows deficit of £6.1m, which is the control total set by the ICS	20	No impact on risk rating
1134	Failure to provide adequate staffing caused by absence relating to COVID-19 resulting in resource challenges and an increase within the temporary staffing domain	• Overall absence rate was 7.44% for April 2022, 6.31% for May 2022, 6.25% for June 2022 and June 2021 absence rate was 5.90% against a target of 4.25% • COVID Related absence rate is 1.42% for May-22, in May-21 it was 1.20%, in June-22 it was 1.47% • Supporting Attendance bitesize briefings on the new policy continue to be offered, these include a focus on Welcome Back Conversations • Full training sessions are planned, due to the success of	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		the current bitesize offering and operational pressures, a decision has been made to continue to offer these at present. • Specific support continues within areas of high N&M sickness and low compliance RTW figures. • The People Directorate have launched a series of Roadshows, where the team host face to face and virtual drop-in sessions to provide a platform for line managers to ask questions and hear about the latest updates to support attendance • Overall vacancy rate was 10.31% for April 2022, 10.80% for May 2022, 10.89% for June 2022 and June 2021 absence rate was 10.4% against a target of 9% • Reliance on bank and agency staff increased to 18.23% in June 2022 compared to a peak of 23.3% in Jan 2021, or 14.72% in May-22. • Administrative & Clerical are experiencing 0.8% absence rate related to COVID-19 in Jun-22 • Estates & Ancillary staff are experiencing over 1% absence rate related to COVID-19 in Jun-22 • Additional Clinical Services are experiencing 2.4% absence rate related to COVID-19 in Jun-22 • Nursing & Midwifery staff experiencing 1.8% absence rate related to COVID-19 in Jun-22 This impacts requirements for temporary staffing.		
1114	FAILURE TO provide essential, optimised digital services in a timely manner in line with best practice governance and security policies, CAUSED BY increasing and competing demands upon finite staffing resources who lack emerging skillsets, sub-optimal solutions or a successful indefensible cyber attack,	• Risks for Cyber on risk register in line of national requirements of the DSPT & NHS Digital • Vulnerability identified by Dedalus obtaining elevated SQL access to data in ORMIS	20	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	RESULTING IN poor data quality and its effects upon clinical and operational decisions / returns and financial & performance targets, reduced operational efficiencies, denial of patient access to services, inferior quality of care including harm, failure to meet statutory obligations (e.g. Civil Contingency measures) and subsequent reputational damage.			
1079	Failure to provide an electronic patient record (EPR) system that can accurately monitor, record, track and archive antenatal (including booking information, intrapartum and postnatal care episodes Caused by an IT system (Lorenzo) which is not maternity specific, currently does not have a robust internet connectivity, inaccurate input of data, inadequate support to cleanse data and no intra-operability between services, for example by the health visitor services Resulting in the inability to capture all required data accurately, to have a robust electronic documentation process in cases of litigation or adverse clinical outcome, poor data quality and inadequate communication with allied services, such as health visitors who are then uninformed of women within the system requiring antenatal assessment. This can also result in women being allocated to the wrong pathway and the wrong payment tariff.	• June 2022 - Women's and Children's CBU in the process of extracting data reports to assess compliance with national maternity data set requirements. Reports are monitored at Women's and Children's monthly Governance meetings.	20	No impact on risk rating
115	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	<u>Assurances</u> • Twice daily review of red flag data to identify staffing, patient acuity and dependency across all clinical areas. • Redeployment of staff (consideration of skill mix) and review allocation of NHS	16	Reduced from 20 to 16

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		Professional pool staff as part of the agreed escalation process. Shifts added to the system, communications sent to all NHS Professional staff to fill shifts. • If required Executive authorisation for off framework agency usage – Greenstaff or Thornbury. • Staffing numbers, skill mix and moves are stored in 'gold command' file for assurance of clinical decision making. • Site Manager and Matron on site until 8pm (Warrington and Halton site). On weekends this is a full day shift. • Rolling recruitment for RN and HCA posts. 2- 4 weekly interviews. • Part of National Recruitment Programme and Care Support Worker Development Programme for HCAs. • Workforce Group in place for monitoring and assurance. • Retention – Transfer policy in place for staff. • Workforce plan/ strategy under review. <u>Gaps</u> • Increased operational capacity and demand results in the need to open additional areas to provide patient care, increasing the staffing need (E.g. B3, CAU and Cath lab). • Increased staffing pressures anticipated due to winter surge. • Time to post when recruiting new staff.		
1372	FAILURE TO deliver the future Electronic Patient Record solution through the Strategic Procurement project in line with the Trust's time, budget and quality requirements CAUSED BY an un-affordable business case due to baseline costs, strong existing benefits & lack of new cash releasing benefits, plus delayed and diluted access to stakeholder	• A revised OBC is being progressed for August/September 2022 Trust Board approval in line with emerging guidance on managed convergence. • Trust Board approved ceasing procurement process a relaunch complying with Managed Convergence is being planned to start November 2022	16	No impact on risk rating

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	support due to operational pressures RESULTING IN continuation of the Trust's challenges with the incumbent EPR, Lorenzo, which were identified in the Strategic Outline Case	• Regular, documented conference calls with the ICS NHSE and NHSD – external partners supportive of managed convergence relaunch. • Business case approved and contract in place for a 3 (+2) year tactical Lorenzo contract in support of time required to complete the procurement and deployment of a new EPR • Trust financial modelling includes 3-year Lorenzo costs • ICB Executive Leads supportive of managed convergence relaunch – with output based specification (OBS) and pre procurement evaluation criteria complying with managed convergence guidance in development • Procurement relaunch to start November 2022 • Senior Programme Manager assigned.		
125	Failure to provide safe, secure, fit for purpose hospitals and environment caused by the age and condition of the WHH estate and limited available resource resulting in a risk to meeting compliance targets, staff and patient safety, increased backlog costs, increased critical infrastructure risk and increased revenue and capital spend.	• Mechanical Craftsperson and Electrician business case approved providing stability of workforce and retention of skills		No impact on risk rating
145	If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, the then Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.	• Clinical strategies at Specialty level are in the processes of being refreshed • Breast Centre of Excellence opened. Bid for targeted investment fund (TIF) to further develop the elective offer at Halton has been prioritised by Cheshire & Merseyside • Bid for Community Diagnostics Centre (CDC) at Halton site submitted • Full Business Case for the Health & Wellbeing Hub approved by the Government • Full Business Case for Health & Education Hub developed for	12	Rating reduced to 12

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		approval. Submission to Government due in August 2022 • Consistent Trust representation within Cheshire & Merseyside ICS to support transition to ICS. WHH CEO appointed as lead for Clinical Pathways within C&M and the Trust is playing an active role within the Cheshire & Merseyside Acute & Specialist Trust (CMAST) provider collaborative. • Discussions with neighbouring Trusts to accelerate collaboration taking place • Formal partnerships developed with key educational partners to enable tailored education & training and research opportunities.		

3 RECOMMENDATIONS

The Board is asked to discuss and approve the changes and updates to the Board Assurance Framework.